

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.14
08135

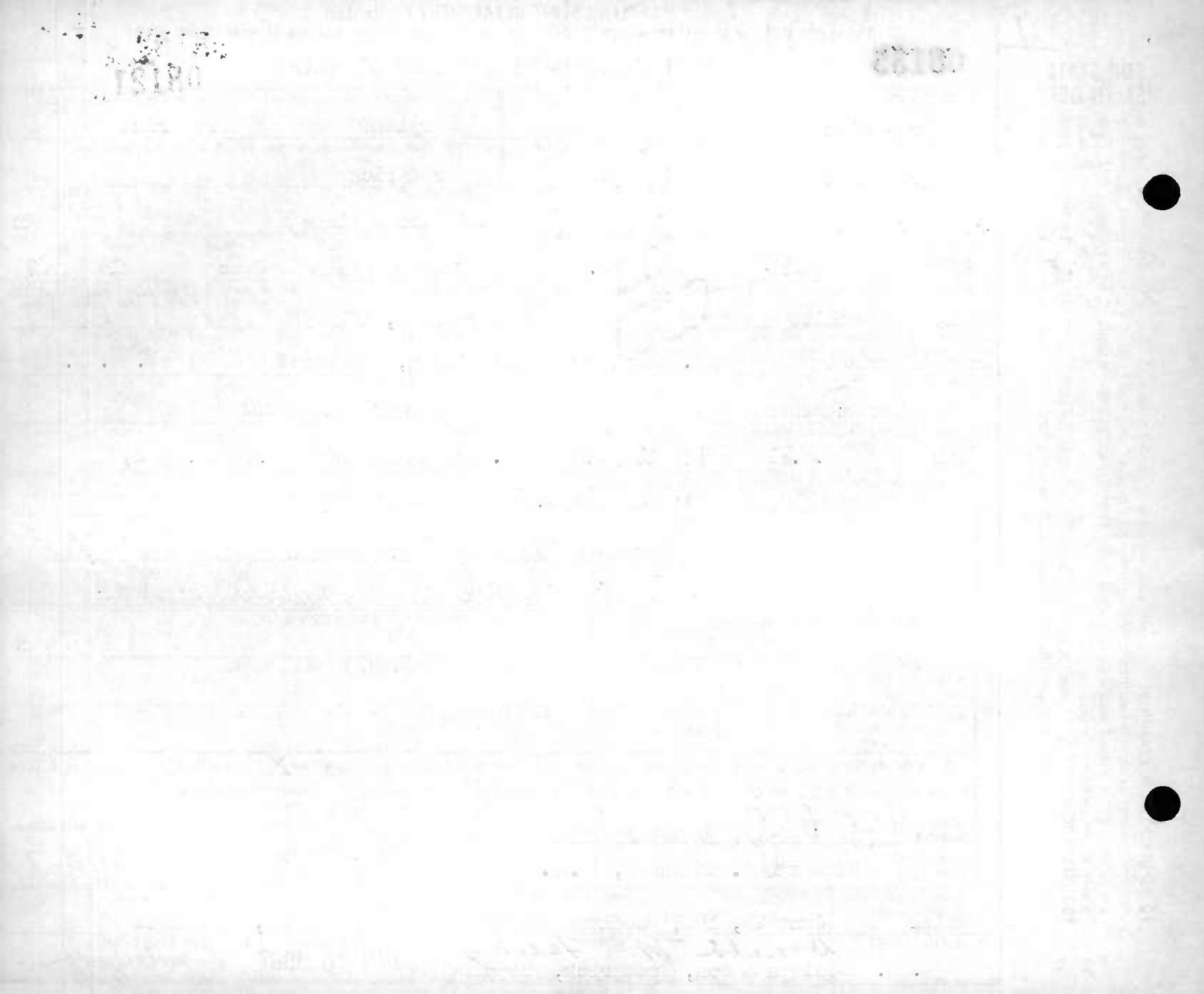
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08121

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Years	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 125 Clarke Place		d. STREET ADDRESS 125 Clarke Place	
3. NAME OF DECEASED (Type or print)	First LLOYD	Middle A.	4. DATE OF DEATH Month AMBROSEN June
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 6, 1913
9. AGE (In years lost birthday) 54 yrs.	10. KIND OF BUSINESS OR INDUSTRY Md. School for Deaf	11. BIRTHPLACE (State or foreign country) Winona, Minnesota	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Gullick Ambrosen	14. MOTHER'S MAIDEN NAME Florence Blanchard		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 476 18 3810	17. INFORMANT Mrs. Mary Ambrosen (Same as item # 2)	Address
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Acute Congestive Heart Failure			INTERVAL BETWEEN ONSET AND DEATH
4201 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) Coronary Artery Occlusion - Myocardial infarction			
DUE TO (c) Arterio-sclerotic Cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20b. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Winona, Minnesota
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Robert J. Thomas</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Winona, Minnesota		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 23, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Winona, Minnesota
24. FUNERAL DIRECTOR Donald M. Etchison & Son, Frederick, Maryland	ADDRESS M. R. Etchison & Son, Frederick, Maryland	25a. RECEIVED BY REGISTRAR DATE JUN 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08136

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08122

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b 5 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First James	Middle Adrain	Last Baker	4. DATE OF DEATH Month June 29, Day 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1884	9. AGE (In years last birthday) 82 yrs.	F UNDER 1 YEAR Months 7	F UNDER 24 HRS. Days 26	Hours 26	Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Loudon Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Charles W. Baker			14. MOTHER'S MAIDEN NAME Mary K. Cooper					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 520-77-2944		17. INFORMANT Address 1400 Kinwick lane Mrs. Evelyn B. McAllister, Silver Spring,		Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6/23/67 , 19, to 6/29/67 , 19, that (I) (we) last saw the deceased alive on 6/29/67 19, and that death occurred at 11:50 a.m. from the causes and on the date stated above.		22b. DATE SIGNED 6/29/67						
22a. SIGNATURE <i>Richard C. Reynolds</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M. D.		22d. ADDRESS Toll House Ave. Frederick, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-1-67		23c. NAME OF CEMETERY OR CREMATORIAL Rohrersville Cemetery		23d. LOCATION (City, town or county) (State) Rohrersville, Md.		
24. FUNERAL DIRECTOR Johm H. Bast, Jr.		ADDRESS		25a. REC'D BY REGISTRAR JUL 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
15M 4-64								

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John Smith

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

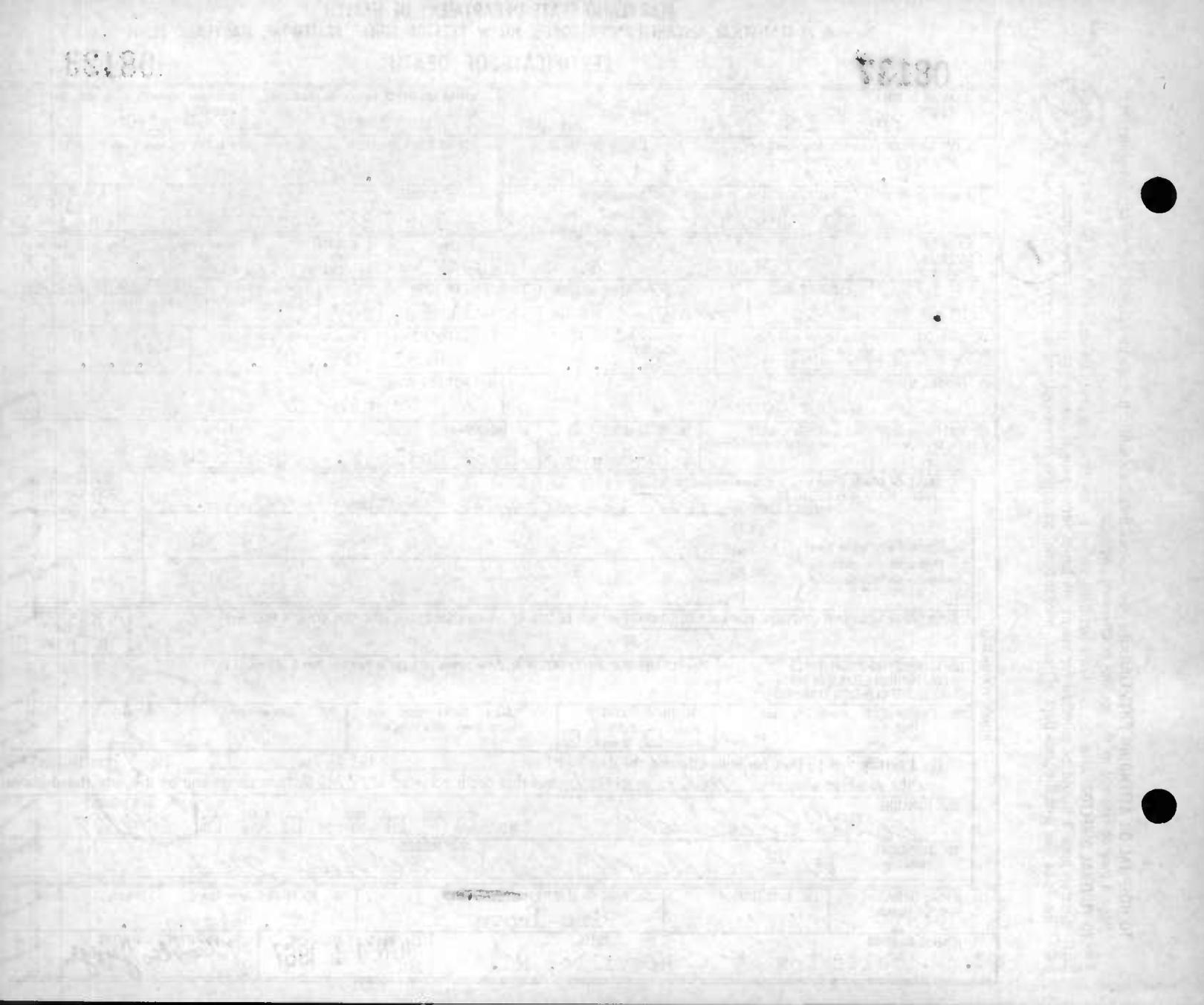
Page 4 may be retained by the hospital or attending physician.
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08137

CERTIFICATE OF DEATH

08123

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 306 Hill Street				d. STREET ADDRESS 306 Hill Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) GILMORE		First A.	Middle BECRAFT	Lost	4. DATE OF DEATH June 9 1967	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH April 25, 1889	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trackman		10b. KIND OF BUSINESS OR INDUSTRY B.& O. R.R.		11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Becraft				14. MOTHER'S MAIDEN NAME Fannie ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-8478		17. INFORMANT Mrs. Della B. Becraft Same As #2		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO 15 years 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ stating the underlying cause (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1955 , to 1967 , that (I) (we) last saw the deceased alive on May 8 1967 , and that death occurred at 7A.M. from causes and on the date stated above.								
22a. SIGNATURE W.B. Culwell		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) W.B. Culwell		22d. ADDRESS Mt. Airy, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/1967		23c. NAME OF CEMETERY Pine Grove		23d. LOCATION (City or Town) (County) (State) Mt. Airy, Md.		
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR DATE JUN 14 1967						
		25b. REGISTRAR'S SIGNATURE Charles Judge						



10
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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08138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08124

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Morgan	
c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkeley Springs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Rt #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Michael	Middle 	Last Benedikt
4. DATE OF DEATH	Month June	Year 22	Doy 1967
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/> X NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 30, 1903
9. AGE (In years last birthday) 63	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Sheet Metal Worker David Taylor Model Basin		10b. KIND OF BUSINESS OR INDUSTRY Germany	
13. FATHER'S NAME Johann Benedikt		14. MOTHER'S MAIDEN NAME Catherine Shretter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Josephine M. Lue	Address 10817 Margate Road Silver Spring, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Shock - Blood loss
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Six car collision	20d. TIME OF INJURY Month, Day, Year 2:30 p.m. 6-22 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) Frederick	(County) Frederick	(State) Md.	21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE <i>Robert J. Thomas</i>	EXAMINER'S NAME (Type) ROBERT J. THOMAS	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Prospect Hill Cemetery
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 27, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Washington, D. C.	23d. LOCATION (City or Town) (County) (State)
C. FUNERAL DIRECTOR Glen Carter Glyn Carter, 8434 Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. ADDRESS Georgia Avenue	25b. REC'D BY REGISTRAR JUN 28 1967
		25c. REGISTRAR'S SIGNATURE Charles Judge	

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08139

CERTIFICATE OF DEATH

08125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Margaret First Elizabeth Middle Betson Lost	4. DATE OF DEATH June 1, 1967	Month	Day Year	
a/k/a Elizabeth Albaugh	Betson	19	67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH January 15, 1913	
9. AGE (In years 1st birthday) 54 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchboard Operator	10b. KIND OF BUSINESS OR INDUSTRY M. J. Grove Lime Co.	11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ingomar W. Albaugh	14. MOTHER'S MAIDEN NAME Oma C. Willett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 578 07 7741	17. INFORMANT Richard K. Betson, Edgemont Rd. Frederick, Md.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast INTERVAL BETWEEN ONSET AND DEATH 6 mos.				
170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1966 , to June 1967 , that (I) (we) last saw the deceased alive on June 1967 , and that death occurred at M , from causes and on the date stated above.				
22a. SIGNATURE GILCIN F. MEADORS		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) GILCIN F. MEADORS, MD		22d. ADDRESS 810 Toll House Ave. Frederick		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 4, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Nr. Hansonville, Maryland	
24. FUNERAL DIRECTOR Donald M. Etchison	ADDRESS Fidelity	25a. REC'D BY REGISTRAR JUN 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	
M. R. Etchison & Son, Frederick, Maryland				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08140

CERTIFICATE OF DEATH

Reg. Dist. No.

08126

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodsboro</i>		c. LENGTH OF STAY IN 1b <i>4 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodsboro</i>		d. STREET ADDRESS <i>Woodsboro</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>BETTY</i>	Middle <i>MAE</i>	Last <i>Biddinger</i>	4. DATE OF DEATH <i>June 16 1967</i>	Month <i>June</i>	Day <i>16</i>	Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Oct 30, 1931</i>	9. AGE (In years lost birthday) <i>35 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dots Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>J. Leslie Biddinger</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Munsenower</i>				Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Carrie M. Biddinger, Woodsboro, Md.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7441</i> DUE TO <i>Acute pulmonary & lung</i>							
Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause (b). DUE TO <i>Pneumonia</i> (c) <i>Muscular Dystrophy</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/16/67</i> to <i>6/16/67</i> , 19 <i>67</i> , that I last saw the deceased alive on <i>6/16/67</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>Thomas A. Love</i>		DATE SIGNED <i>6/17/67</i>					
PHYSICIAN'S NAME (Type) <i>THOMAS A. LOVE.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/18/67</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Chapel Cem.</i>		22d. LOCATION (City, town, or county) <i>Mr. Libertytown, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.C. Barton, Walkersville, 21793</i>		ADDRESS 24a. REC'D BY REGISTRAR, 24b. REGISTRAR'S SIGNATURE DATE <i>JUN 20 1967 Charles Jagger</i>					

MARYLAND STATE DEPARTMENT OF HEALTH - DEATHBOOK 10

CERTIFICATE OF DEATH

03180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08141

CERTIFICATE OF DEATH

08127

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

1 day

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hosp

3. NAME OF DECEASED

(Type or print)

First **SYLVESTER** Middle **ARNOPHIS**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

b. COUNTY

Maryland

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

New Midway

d. STREET ADDRESS

101

e. IS RESIDENCE ON A FARM?

YES NO

S. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

Last

4. DATE OF DEATH

Month **June**

Day **22**

Year **1967**

B. DATE OF BIRTH

9. AGE (In years last birthday)

66

IF UNDER 1 YEAR

Months **6**

Days **0**

Hours **0**

Min. **0**

yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

own farm

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

--

14. MOTHER'S MAIDEN NAME

Laura Boston

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO.

212-40-6233

17. INFORMANT

Mrs Lola A. Boston, Keymar, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Acutal cerebro hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH
30 minutes

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

Arteriosclerotic cardio-vascular disease

about 5
years

DUE TO

(c)

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m.
p.m.

19

20d. INJURY OCCURRED

While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from

April 1960

to *6/22*, 1967, that (I) (we) last

saw the deceased alive on

6/21, 1967, and that death occurred at

12:05 A.M. from the causes and on the date stated above.

22e. SIGNATURE

Ernest A. Dettbarn

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

22c. PHYSICIAN'S NAME (Type)

ERNEST A. DETTBARN

22d. ADDRESS

Walkersville, Md.

6/23/67

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

6/25/67

23c. NAME OF CEMETERY OR CREMATORIUM

Rocky Hill Cem

23d. LOCATION (City, town or county)

Woodsboro

(State)

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

G.C. Barton, Walkersville, Md.

ADDRESS

25a. REC'D BY REGISTRAR

JUN 27 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

181

23.80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

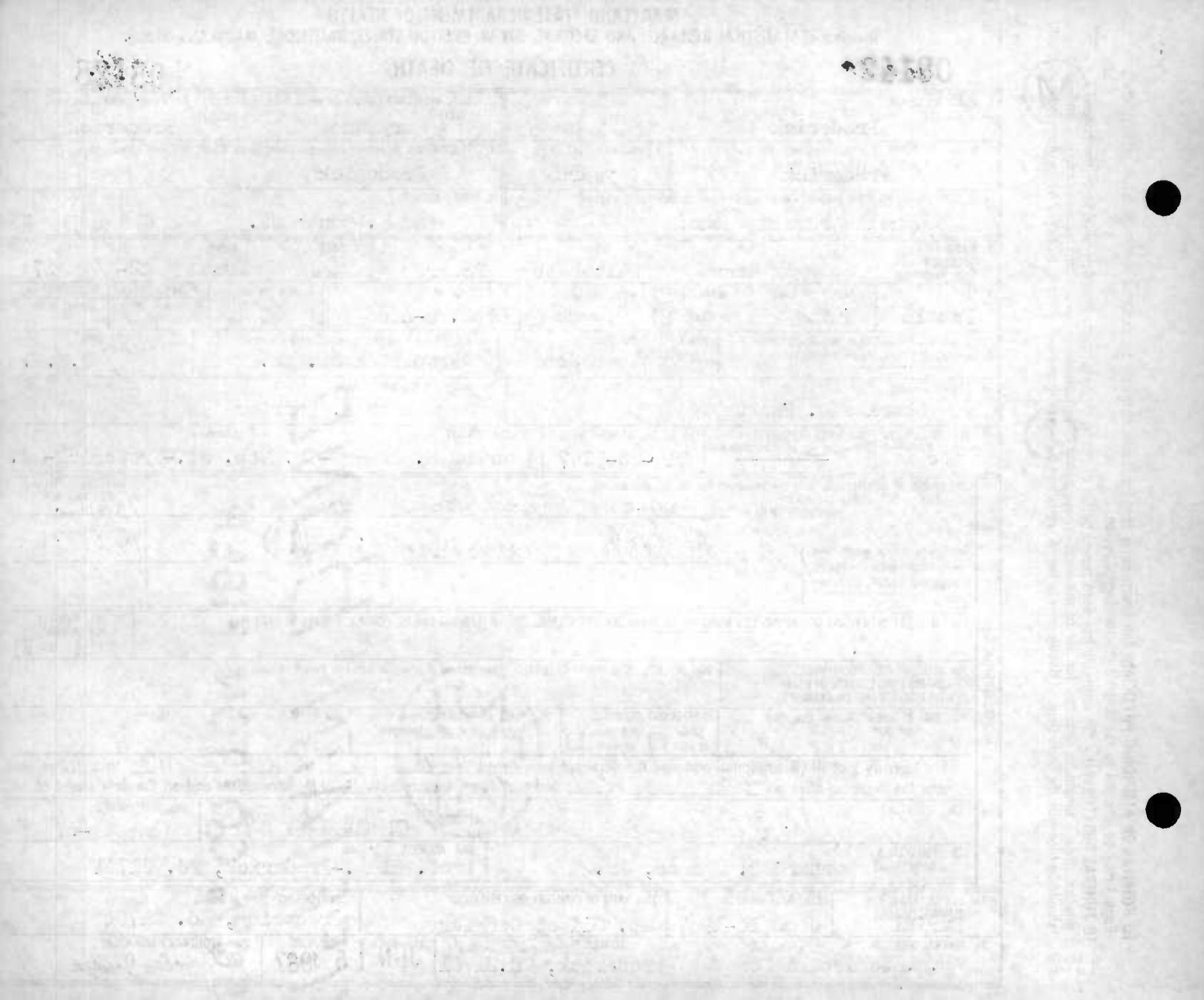
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08142

CERTIFICATE OF DEATH

03128

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wynelle Nursing Home			d. STREET ADDRESS 48 E. South St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Mary	Middle Elizabeth	Last Bowers	4. DATE OF DEATH June 12- 19 67	Month Doy Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Sept. 6-1886	9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles O. Phebus			14. MOTHER'S MAIDEN NAME Sarah E. Burrier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-5287		17. INFORMANT Laurens N. Bowers - E. 7th. St.-Frederick-Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arterio-sclerotic C.V.D. DUE TO (c) Diabetes INTERVAL BETWEEN ONSET AND DEATH 10 min.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes INTERVAL BETWEEN ONSET AND DEATH 15 years.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At home	20f. (City or town) Frederick	(County) Md.	(State) 21701
21. I certify that (I) (this hospital) attended the deceased from April 1, 1967 to June 12, 1967 , that (I) (we) last saw the deceased alive on June 11, 1967 , and that death occurred at 10:45 A.M. from causes and on the date stated above.						
22a. SIGNATURE Bernard O. Thomas Jr.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED June 13-67
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr.		22d. ADDRESS Prof. Bldg.-Frederick, Md. 21701				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 16-1967	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION (City or Town) Frederick, Md. 21701	
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son		ADDRESS Whitmore Frederick, Md. 21701	25a. REC'D BY REGISTRAR DATE JUN 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08143

CERTIFICATE OF DEATH

08129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Braddock Hgts.		c. LENGTH OF STAY IN lb 8 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Vindobona Nursing Home			d. STREET ADDRESS 104 Clarke Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Viola Middle Rebecca Last Bowers		4. DATE OF DEATH Month June Day 11-- Year 19 67					
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12- 1889	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry W. Bowers			14. MOTHER'S MAIDEN NAME Anna Isabel Fox			Address Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No		16. SOCIAL SECURITY NO. 220-48-7559		17. INFORMANT Mrs. Eliz. Ordman-104 Clarke Place-Frederick-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraestablie Cardiae failure			INTERVAL BETWEEN ONSET AND DEATH 2 yrs				
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A - S. heart dis			DUE TO (c)			?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe intraestablie maesalgie Anemia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Opril (County) 1965 (State) ta 11 June, 1967	
21. I certify that (I) (this hospital) attended the deceased from April , 1965, to 11 June , 1967, that (I) (we) last saw the deceased alive on 8 June , 1967, and that death occurred at 1:30AM , from causes and on the date stated above.							
22a. SIGNATURE Charles H. Conley, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 12-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Charles H. Conley-Jr.		22d. ADDRESS Professional Bldg.-Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 14-1967		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION (City or Town) Frederick, Md. 21701 (County) (State)	
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son		ADDRESS Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR DATE JUN 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

HOSPITAL TO be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08144

08130

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural - Mt. Airy

c. LENGTH OF STAY IN lb

years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Route 1

**3. NAME OF DECEASED
(Type or print)**

First

Middle

Last

Clyde

Willis

Boyer

4. DATE OF DEATH

June

10

1967

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Oct. 18- 1905

9. AGE (In years last birthday)

61 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Saw Mill Operator

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willis Boyer

14. MOTHER'S MAIDEN NAME

Laura Haugh Hobbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

217-28-1265

17. INFORMANT

Mrs. Frances Carpenter Boyer-Rt. 1- Mt. Airy- Address

Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

1621

Pulmonary edema

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

Bronchogenic carcinoma

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

4 days

about 10 months

2. MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour

a.m.

p.m.

Month, Day, Year

Whila

Not Whila

at work

at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (This hospital) attended the deceased from Nov. 26 1966, to June 10, 1967, that (I) (we) last saw the deceased alive on April 29 1967, and that death occurred at 11:55 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Ernest A. Dettbarn

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

June 11-67

22c. PHYSICIAN'S NAME (Type)

ERNEST A. DETTBARN

22d. ADDRESS

WALKERSVILLE, MD. 6/10/67

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

June 13-1967

23c. NAME OF CEMETERY OR CREMATORIUM

Mt. Olivet Cemetery

23d. LOCATION (City, town or county) (State)

Frederick, Md. 21701

24 FUNERAL DIRECTOR'S SIGNATURE

Elwood

ADDRESS T. Whitmore

Frederick, Md. 21701

25a. REC'D BY REGISTRAR

JUN 15 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

1968

1968

1968

A

b

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08145

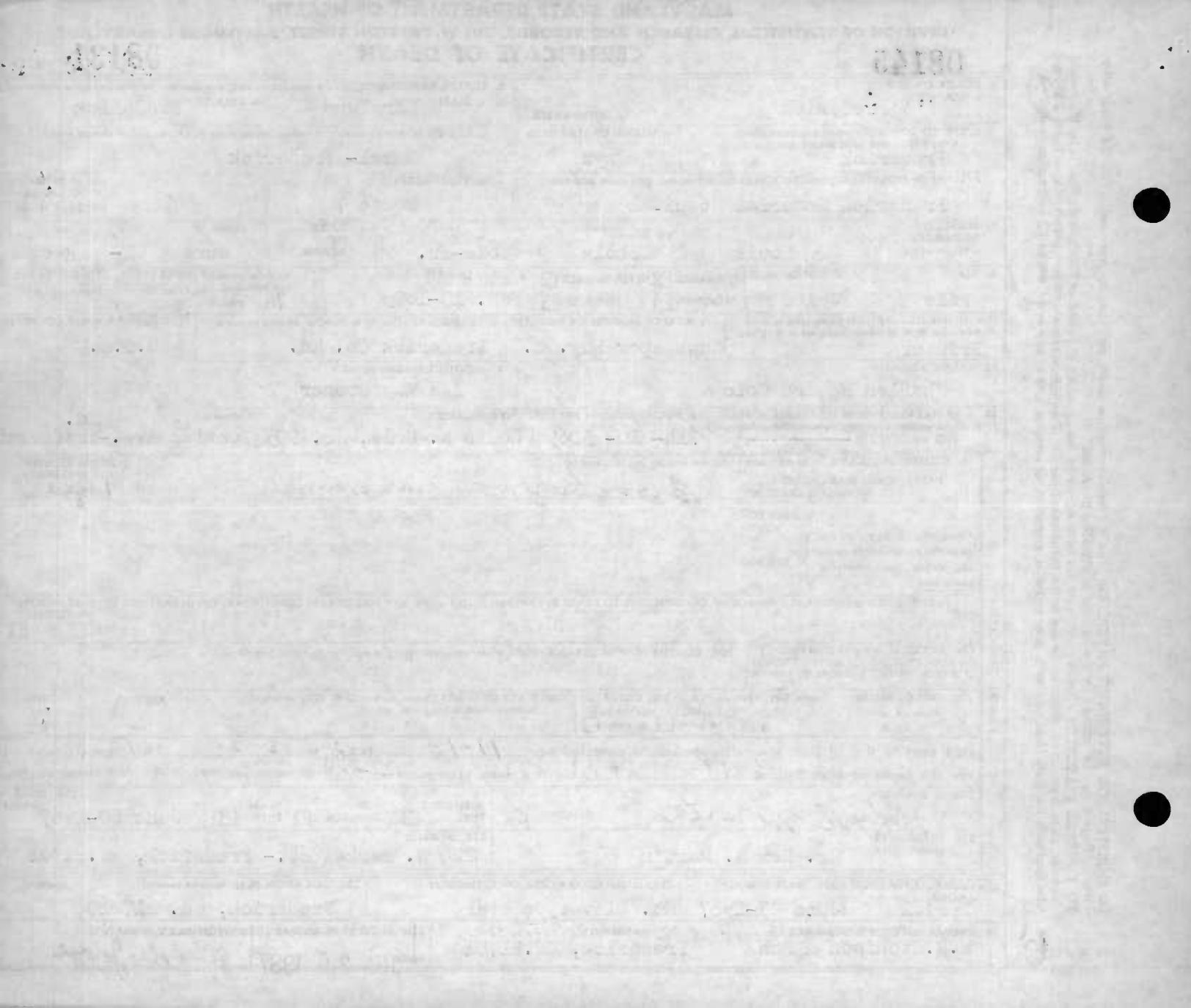
CERTIFICATE OF DEATH

08131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Route 7	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louis Middle Nichols Last Cole-Sr.		4. DATE OF DEATH Month June Day 20 Year 19 67	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Feb. 13-1893 9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer 11b. KIND OF BUSINESS OR INDUSTRY Newspaper Pbg. Co. 11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Edward Cole		14. MOTHER'S MAIDEN NAME Ida May Stoner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 214-10-3065 17. INFORMANT Louis N. Cole, Jr. 905 Pontiac Ave.-Frederick		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 16.21 <i>Bronchogenic carcinoma</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-1-1965 to 6-20-1967, that (I) (we) last saw the deceased alive on 6-19-1967, and that death occurred at 12-15a.m. from the causes and on the date stated above.			
22a. SIGNATURE <i>Rex R. Martin</i>		M.D. 22b. DATE SIGNED June 20-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 220 N. Market St.- Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 23-1967 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery 23d. LOCATION (City, town or county) Frederick, Md. 21701	
24. FUNERAL DIRECTOR'S SIGNATURE Elwood T. ADDRESS Whitmore M.R.Etchison & Son Frederick, Md. 21701		25a. REC'D BY REGISTRAR DATE JUN 26 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08146 08132

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND		b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKY RIDGE		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKY RIDGE		d. STREET ADDRESS —			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First JOHN	Middle ASA	Last Colson	4. DATE OF DEATH JUNE 12 1967	Month JUNE	Doy 12	Year 1967	
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH APR 25-1875	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —	Hours —	Min. —
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WESTERN UNION		10b. KIND OF BUSINESS OR INDUSTRY LINEMAN							
13. FATHER'S NAME WILLIAM COLSON		14. MOTHER'S MAIDEN NAME MARGARET PICKETT							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-48-6412		17. INFORMANT MRS HAROLD BOLLINGER		Address Rocky Ridge			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Cardiac Dystrophy						INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. General arteriosclerosis		(b) DUE TO General arteriosclerosis	(c)			10 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis offiliaryis fifth bldg - Basal Cerebral sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from 1963 , 19, to 1967 , 19, that (1) (we) last saw the deceased alive on 6-1-67 , and that death occurred at 31A M, from causes and on the date stated above.		22b. DATE SIGNED 6-19-67							
22a. SIGNATURE Thomas A. Love		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Thomas A. Love, M.D.		22d. ADDRESS Hagerstown Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/14/67		23c. NAME OF CEMETERY OR CREMATORY WESTERN		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD			
24. FUNERAL DIRECTOR Dr Hartley & Sons New Windsor, Md		ADDRESS —		25a. REC'D BY REGISTRAR DATE JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

22626

CHARTER 2000 EDITION 2000 AUGUST 2000
REF ID: 30 300000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08147

CERTIFICATE OF DEATH

08133

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Walkersville

c. LENGTH OF STAY IN b

9 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Liberty St.

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

CHARLES EDWARD CONAWAY

4. SEX

6. COLOR OR RACE

M

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

Dec 22, 1921

9. AGE (In years
last birthday)

45 yrs.

10. IF UNDER 1 YEAR

Months Deys

11. IF UNDER 24 HRS.

Hours Min.

June

26

1967

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

10b. KIND OF BUSINESS OR INDUSTRY

Farm Machinery

11. BIRTHPLACE (County & State, or foreign country)

Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY?

M.S.A.

13. FATHER'S NAME

Jolly M. Conaway

14. MOTHER'S MAIDEN NAME

Stella Poole

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-18-3009

17. INFORMANT

Mrs Catherine Conaway, Walkersville, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Generalized concormatone

1531

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Caecum of transverse colon

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

3 months

6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1967 to June 26, 1967, that (I) (two) last
saw the deceased alive on June 25, 1967, and that death occurred at... AM, from the causes and on the date stated above.

22a. SIGNATURE

Ernest A. Dettbarn

M.D.

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

ERNEST A. DETTBARN

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 6/28/67

23b. DATE THEREOF

Glade Cem.

23d. LOCATION (City, town or county)

Walkersville

(State)
Md.

24 FUNERAL DIRECTOR'S SIGNATURE

G.C. Barton, Walkersville, md. 21793

ADDRESS

25a. REC'D BY REGISTRAR JUN 29 1967

25b. REGISTRAR'S SIGNATURE
DATE

75160

CHARTERED ACCOUNTANT
1511 22 2011 W 15
and to meet you and your
wife for a few moments
and you will be pleased to know

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08148

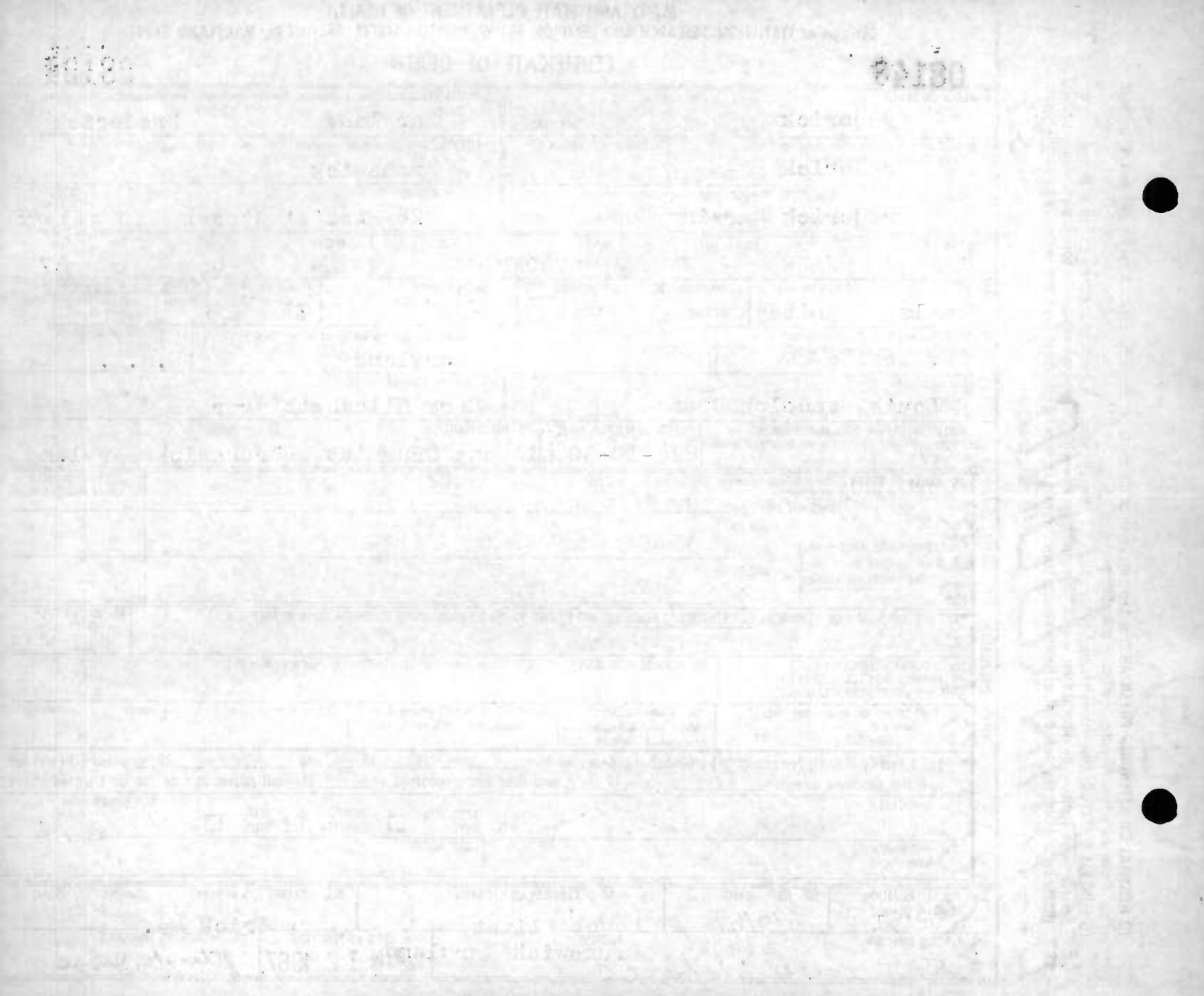
CERTIFICATE OF DEATH

08134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Frederick MARYLAND		Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 10-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Nursing Home		d. STREET ADDRESS 928 East 'A' Street e. IS RESIDENCE ON A FARM? e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First JANE Middle JEMIMA CRUMMITT		4. DATE OF DEATH Month 6 Doy 6 Year 167	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/22/95 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Randolph Crum		14. MOTHER'S MAIDEN NAME Mary Elizabeth Baer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO. A- 214-10-3084 17. INFORMANT Alonza Crummitt Address Brunswick Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>CREMIA</u>		INTERVAL BETWEEN ONSET AND DEATH	
260X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <u>DIABETES</u> (c) <u>ASHD & CHF</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>Anemia UT</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1962</u> , to <u>June 1967</u> , that (I) (we) last saw the deceased alive on <u>6/5/67</u> 19 <u>67</u> , and that death occurred at <u>1201</u> M, from causes and on the date stated above.		22b. DATE SIGNED <u>6/8/67</u>	
22a. SIGNATURE <u>A. Austin Lane Jr.</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/9/67</u>	23c. NAME OF CEMETERY OR CREMATORIALy <u>Mount Olivet</u>
24. FUNERAL DIRECTOR <u>Teete Funeral Home</u>		ADDRESS <u>Bruswick Maryland</u>	23d. LOCATION (City or Town) (County) (State) <u>Frederick Md.</u>
			25a. REC'D BY REGISTRAR <u>JUN 12 1967</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08135

08149

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue Home			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle E.	Lost DeGRANGE	4. DATE OF DEATH June 29, 1967	Month Doy Year	
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 18, 1878	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own gen. farm		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David DeGrange		14. MOTHER'S MAIDEN NAME Josephine Hoffman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 20-16-2790		17. INFORMANT C. Albert DeGrange, Middletown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Cerebral vascular accident DUE TO 7 days 331X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) Arteriosclerotic vascular disease DUE TO 5 years. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Middle (County) Middle (State) Middle	
21. I certify that (I) (this hospital) attended the deceased from May , 19 67 , to June 29, 1967 , that (I) (we) last saw the deceased alive on June 29, 1967 , and that death occurred at 3:00 P.M. from causes and on the date stated above.						22b. DATE SIGNED 6/29/67	
22a. SIGNATURE LeRoy T. Davis		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/29/67	
22c. PHYSICIAN'S NAME (Type) LeRoy T. Davis		22d. ADDRESS Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1, 1967		23c. NAME OF CEMETERY OR CREMATORIAL United Brethren		23d. LOCATION (City or Town) Myersville (County) Fred. Co. (State) Md.	
24. FUNERAL DIRECTOR Paul F. Bittle		ADDRESS Paul F. Bittle, Myersville, Md.				25a. REC'D BY REGISTRAR JUL 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08150

CERTIFICATE OF DEATH

08136

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Buckeystown Years		c. LENGTH OF STAY IN 1b Buckeystown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Anna Laura Derr		First Anna	Middle Laura
4. DATE OF DEATH June 6-19 1967	Last Derr	Month June	Day 6
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIOOWEO <input type="checkbox"/> DIVORCEO <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30-1886
10a. RURAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 80 yrs.	11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.
13. FATHER'S NAME Charles Edward Derr	14. MOTHER'S MAIDEN NAME Anna Mary Zimmerman	12. CITIZEN OF WHAT COUNTRY? U.S.A.	Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-34-2407	17. INFORMANT Mrs. C.E.Nichols-Buckeystown, Md. 21717	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bladder cancer 1810 OUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10 , 1967, to 6-6- , 1967, that (I) (we) last saw the deceased alive on 6-4- 1967, and that death occurred at 7 p.m. M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Rex R. Martin</i>	22b. DATE SIGNED June 7-1967		
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 220 N. Market St.-Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 9-1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Olivet Cemetery Whitmore	23d. LOCATION (City, town or county) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR M.R.Etchison & Son	25a. REC'D BY REGISTRAR JUN 14 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

60126

Hedderick

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Hedderick

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Buckeleytown

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Hawthorne Mifflin

U.S.A.

Hedderick Co. Md.

Hornbeam Park

Yours Isela Zimmerman

Chaffee Building Dept

No STV-3A-ST03 Mrs. C.E. Nichols-Buckeleytown, Md. 21313

xx

J.B.W.

June 3-1963

x

220 N. Market St.-Hedderick, Md. 21301

Dr. Max R. Martin

Hedderick, Md. 21301

Burris June 8-1963

W.R. Chapman & Son

Hedderick, Md. 21301

W.R. Chapman & Son

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08151				CERTIFICATE OF DEATH				08137					
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 141 East 6th Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Austin				First	Middle	Last	4. DATE OF DEATH June 8, 1967				Doy	Year	
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1919				9. AGE (In years at birthday) 48 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	White									Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Curtis Devilbiss				14. MOTHER'S MAIDEN NAME Roberta Powell									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No			16. SOCIAL SECURITY NO. 217-10-0390			17. INFORMANT Mrs. Mary G. Devilbiss 141 E. 6th St. Fred. Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Congestive Heart Failure Bronchiogenic Carcinoma								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis of liver; bleeding Esophageal Varices												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) injury									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 1957, to 6-8-, 1967, that (I) (we) last saw the deceased alive on 6-7- 1967, and that death occurred at 743 M, from causes and on the date stated above.													
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 6-8-67					
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin M.D.				22d. ADDRESS 220 N. Market Street Frederick, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-12-1967		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery				23d. LOCATION (City or Town) (County) (State) Frederick, Maryland					
24. FUNERAL DIRECTOR 				ADDRESS Frederick, Maryland				25a. REC'D BY REGISTRAR JUN 12 1967		25b. REGISTRAR'S SIGNATURE 			

12180

01000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08152

CERTIFICATE OF DEATH

08138

1. PLACE OF DEATH a. COUNTY FREDERICK	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	b. COUNTY FREDERICK	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FREDERICK	c. LENGTH OF STAY IN 1b 3 WKS	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FREDERICK	d. STREET ADDRESS RT.#7 OLD RECEIVER RD.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FREDERICK MEM. HOSP.	604	e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	104	
3. NAME OF DECEASED (Type or print) ETHEL	First MAE	Middle DREW	4. DATE OF DEATH 6 21 1967	
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-1901	
		WIOOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SORTER	10b. KIND OF BUSINESS OR INDUSTRY FRUIT PACKING	11. BIRTHPLACE (County & State, or foreign country) WELLSBORO PA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES A. TAYLOR	14. MOTHER'S MAIDEN NAME LEONA FRANCES FRENCH	Address FREDERICK, MD.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 564 09-4074	17. INFDRMAN MELVINE E. DREW	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension arteriosclerotic, cardiovascular 287X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) + possibly cerebral vascular disease. DUE TO DUE TO DUE TO Obesity, exogenous, severe. C PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	INTERVAL BETWEEN ONSET AND DEATH 5-6 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-12 , 19 67 , to 6-21 , 19 67 , that (I) (we) last saw the deceased alive on 6-12 19 67 , and that death occurred at M , from the causes and on the date stated above.	22a. SIGNATURE Rex R. Martin	22b. DATE SIGNED 6-21-67		
22c. PHYSICIAN'S NAME (Type) Rex R. Martin	M.O. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 220 N. MARKET Frederick, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-24-67	23c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET	23d. LOCATION (City, town or county) (State) FREDERICK	
24. FUNERAL DIRECTOR SALAMONE FUNERAL HOME	ADDRESS FREDERICK, MD.	25a. REC'D BY REGISTRAR DATE JUN 26 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

24180

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08153

CERTIFICATE OF DEATH

08139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

909 Pine Avenue

3. NAME OF
DECEASED
(Type or print)

First

Middle

ROY

HENRY

4. SEX

6. COLOR OR RACE

Male

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

9. AGE (in years
last birthday)

March 16, 1891

76

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Retired

Maryland

State Roads

13. FATHER'S NAME

George Dutrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

215 34 3422

Mrs. Pearl Dutrow (Same as item # 2)

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

Generalized carcinomatosis

INTERVAL BETWEEN
ONSET AND DEATH

6 mos.

177X
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO

(b)

Prostatic carcinoma

DUE TO

(c)

2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Arteriosclerosis cardio vascular disease

19. WAS AUTOPSY PERFORMED?

YES NO 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

While at work

Not While at work

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 18, 1967, to June 27, 1967, that (I) (we) last saw the deceased alive on June 27, 1967, and that death occurred at 9:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

P. J. Dett Barn

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED

6/28/67

22c. PHYSICIAN'S
NAME (Type)

E. A. DETTBARN

, M. D.

22d. ADDRESS

Wallaceville, Md.

23e. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

June 30, 1967

Lutheran Cemetery

23c. NAME OF CEMETERY OR CREMATORIUM

Middletown, Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

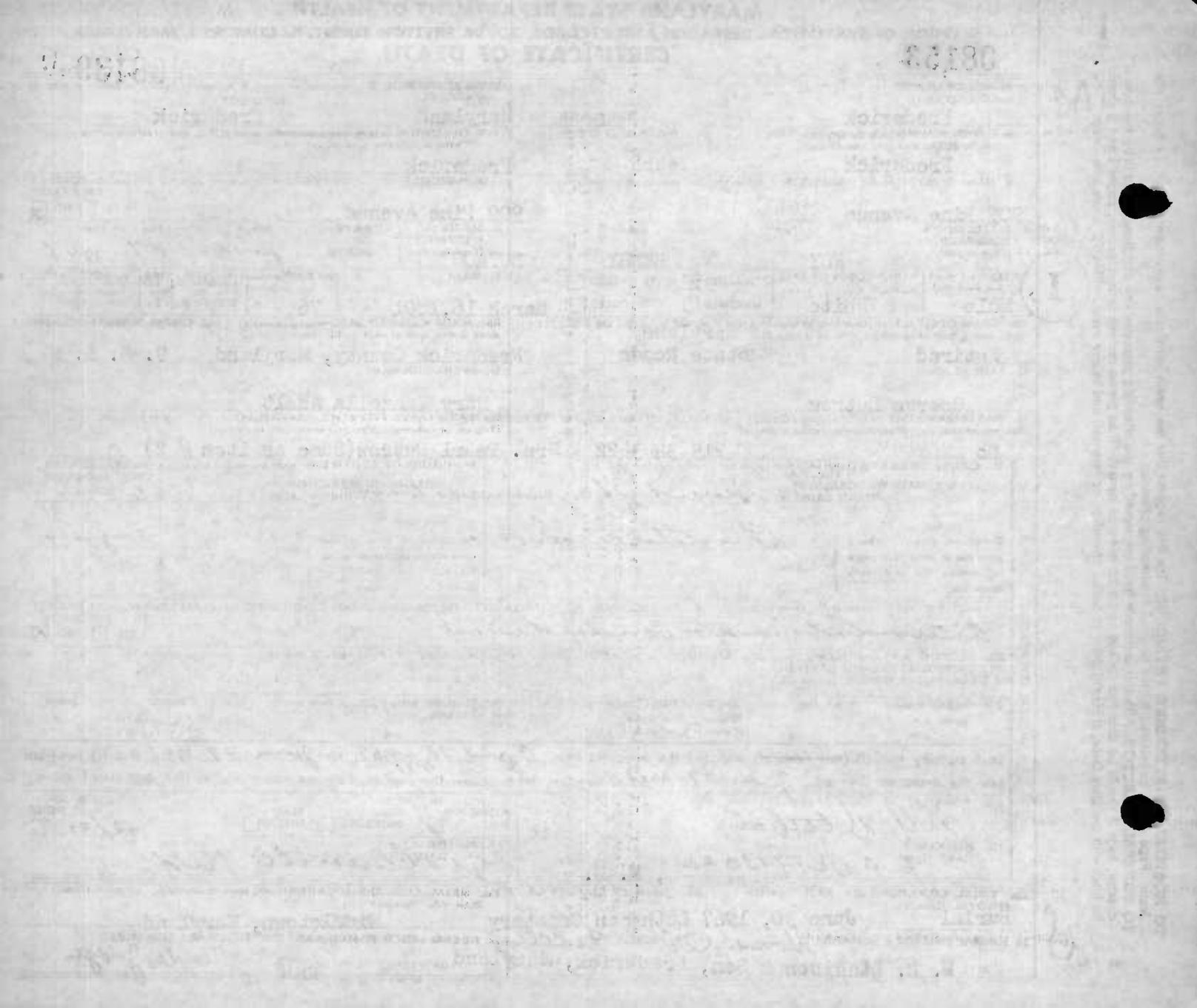
Donald M. Faleley
M. R. Etchison & Son, Frederick, Maryland

25e. REC'D BY REGISTRAR

25f. REGISTRAR'S SIGNATURE

DATE JUN 30 1967

Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			08140		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)													
a. COUNTY <i>Frederick</i>				a. STATE <i>MARYLAND</i>													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Braddock</i>				c. LENGTH OF STAY IN 1b <i>4 days</i>													
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				d. STREET ADDRESS <i>422 Sherman Ave.</i>													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Windobona Convalescent Home</i>				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <i>DAVID RODNEY FOX</i>				First	Middle	Last	4. DATE OF DEATH <i>June 7 1967</i>	Month	Day	Year							
5. SEX <i>M</i>				6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6, 1896</i>	9. AGE (in years last birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/>	11. IF UNDER 24 HRS. <input type="checkbox"/>	12. IF UNDERR 24 HRS. <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance Engineer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy</i>													
13. FATHER'S NAME <i>Hesekiah Fox</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Frederick Co., Md.</i>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>578-03-5211A</i>													
17. INFORMANT <i>Mrs. Mildred E. Fox, 422 Sherman Ave., Fred.</i>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PARKINSON'S Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>													
350X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) <i>Sensitivity</i>													
				DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Woodsboro</i>		(County) <i>Frederick</i>		(State) <i>Md.</i>					
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> , to <i>6-7-1967</i> , that (I) (we) last saw the deceased alive on <i>6-5-1967</i> , and that death occurred at <i>422 Sherman Ave.</i> M, from the causes and on the date stated above.																	
22a. SIGNATURE <i>Rex R Martin</i>				22b. DATE SIGNED <i>6/7/67</i>													
22c. PHYSICIAN'S NAME (Type) <i>Rex R Martin</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>Frederick Md</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>6/10/67</i>				23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Hope Cemetery</i>				23d. LOCATION (City, town or county) <i>Woodsboro</i>					
24. FUNERAL DIRECTOR <i>G.C. Barton, 40 Fulton Ave., Walkersville, Md.</i>				ADDRESS <i>111 N. Main St., Walkersville, Md.</i>				25a. REC'D BY REGISTRAR <i>Charles J. Barton</i>				25b. REGISTRAR'S SIGNATURE <i>Charles J. Barton</i>					
VR A15 (4) 20M 1/65				DATE <i>JUN 12 1967</i>													

112188

112180



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08155

CERTIFICATE OF DEATH

08141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural- Frederick

c. LENGTH OF STAY IN lb

years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Route 4

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Harvey

Rayue

Fox

4. DATE
OF
DEATH

June

7-

19 67

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

July 27-1887

9. AGE (In years
last birthday)

79

yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

12. IS RESIDENCE
ON A FARM?YES NO

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Carpenter

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John W. Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

Yes

WWar 1

16. SOCIAL SECURITY NO.

214- 16-0286 Mrs. Helen Stokes Fox- Route 4-Frederick, Md.

Address

17. INFORMANT

Part I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH
5 minutes

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Arterio sclerotic C.V.D.

10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 2, 1955 to June 7, 1967, that (I) (we) last saw the deceased alive on June 2, 1967, and that death occurred at 6 p.m. from the causes and on the date stated above.

22a. SIGNATURE

B.O. Thomas Jr.

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
June 8-196722c. PHYSICIAN'S
NAME (Type)

Dr. B.O. Thomas Jr.

22d. ADDRESS

Prof. Bldg.- Frederick, Md. 21701

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

June 10-1967

23c. NAME OF CEMETERY OR CREMATORIAL

Pleasant Hill Cemetery

23d. LOCATION (City, town or county)

(State)

Nr. Yellow Springs, Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Elwood T.

ADDRESS Whitmore

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

M.R. Etchison & Son

Frederick, Md. 21701

DATE JUN 12 1967

Charles Judge

Q122

W.H. Ferguson & Son Ledgerer Co., Inc. 11. B.O. Powers - Jr.
Harrisburg, Pa. 110-10-1863 11. Yellow Sulphur, Md. S101
W.H. Ferguson & Son Ledgerer Co., Inc. 11. Yellow Sulphur, Md. S101
June 10-1863 Harrisburg, Pa. 11. Yellow Sulphur, Md. S101
x

B

Y

John J. Box 271-19-0288 Helen Stokes Box - Route 1 - Mechanicsburg, Pa.
M.L.A. Atkinson Cashier Ledgerer Co., Inc. 11.8.11
Route 1 Box 271-19-0288 Helen Stokes Box - Route 1 - Mechanicsburg, Pa.
Hannay Davis Cashier Ledgerer Co., Inc. 11.8.11
Route 1 Box 271-19-0288 Helen Stokes Box - Route 1 - Mechanicsburg, Pa.
Wife Mifflin 271-19-0288 Helen Stokes Box - Route 1 - Mechanicsburg, Pa.
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and in any event within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08156

CERTIFICATE OF DEATH

08142

**1. PLACE OF DEATH
a. COUNTY**

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

DOA- Frederick Memorial Hospital

**3. NAME OF
DECEASED
(Type or print)**

Samuel

First

Middle

Last

Gardner

Sr.

5. SEX

Male

White

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

Month

Day

Year

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

No

212-05-0823

Miss Helen M. Gardner-299 Rockwell Terrace-

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4201

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

suspect

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Hypertension, Emphysema

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While Not While

at work at work

20e. PLACE OF INJURY(Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Sept 19, 1967, to May 1, 1967, that (II) (we) last
saw the deceased alive on June 19, 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Thomas S. Stone

M.D. ATTENDING MED.
PHYS. DIRECTOR STAFF
PHYS.

22b. DATE SIGNED

6-1-67

22c. PHYSICIAN'S
NAME (Type)

Thomas S. Stone

22d. ADDRESS

Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

June 3-1967

23c. NAME OF CEMETERY OR CREMATORIUM

Mt. Olivet Cemetery

ADDRESS

Whitmore

23d. LOCATION (City, town or county) (State)

Frederick, Md. 21701

24. FUNERAL DIRECTOR

Elwood T. Etchison & Son

ADDRESS

Frederick, Md. 21701

25a. REC'D BY REGISTRAR

Charles J. Judge

25b. REGISTRAR'S SIGNATURE

M.R. Ferguson & Son - Bredenfisch Ltd

ST-02-0853 Miss Helen M. Gardner-206 Rockwell Street -
Furniture -
Wardrobe -
Master's Room
Miss Helen M. Gardner -
Poco Haven -
Jefferson Co.
Retired
Mr. E. Gardner

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
08157

CERTIFICATE OF DEATH

1
08143

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge		c. LENGTH OF STAY IN lb 17 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM H. GEARHART		First WILLIAM	Middle H.
4. DATE OF DEATH June 23	Month June	Day 23	Year 1967
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-19-1903	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired	10b. KIND OF BUSINESS OR INDUSTRY Rented Farm	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME John Gearhart		14. MOTHER'S MAIDEN NAME Ida Cline	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 183-12-4698	17. INFORMANT Address Harvey J. Gearhart Rocky Ridge, Md. #
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1603X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)		<i>Carcinoma of the lung</i> INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Emmitsburg, Md.
20f. (City or town) Emmitsburg		(County) Frederick Co.	(State) Md.
21. I certify that ① (this hospital) attended the deceased from 1959 , 19, to 6/18/67 , 19, that ① (we) last saw the deceased alive on 6/18/67 , 19, and that death occurred at 1:30 P.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>George Morningstar</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) George Morningstar		22d. DATE SIGNED 6/24/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-26-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Tabor Cemetery Thurmont, Md.
24. FUNERAL DIRECTOR Raymond E. Creager		25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
20 M 1/66		DATE JUN 27 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

2

Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08144

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00 Route 3		d. STREET ADDRESS Route 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eva Viola Gibbons		First Eva	Middle Viola
Last Gibbons		4. DATE OF DEATH June 25-- 19 67	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Mayberry Giffit		14. MOTHER'S MAIDEN NAME Martha Ellen Holmes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-18-0485	
17. INFORMANT Mrs. Maxine Staub- Route 3-Frederick, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASTHMA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Robert J. Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) M.D.	
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.		22. DATE SIGNED 6/25/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 28-67	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23e. REC'D BY REGISTRAR JUN 28 1967	
24. FUNERAL DIRECTOR M.R. Etchison & Son		25b. REGISTRAR'S SIGNATURE Charles Judge	

APPROVED BY

SSO-19-0492

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08153

CERTIFICATE OF DEATH

08145

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg,		c. LENGTH OF STAY IN lb 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg,		d. STREET ADDRESS						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Roy		First Franklin	Middle Glass	4. DATE OF DEATH June 20, 1967	Month June	Doy 20	Year 1967					
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 19, 1902	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & School Bus			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Lee Co. Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William E. Glass				14. MOTHER'S MAIDEN NAME Sarepta Orshorn				Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 217-32-6948			17. INFORMANT Mrs. Roy F. Glass, Emmitsburg, Md. R.D. #2			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - hypertension DUE TO arterosclerotic c.v disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes Mellitus DUE TO advanced osteoarthritis INTERVAL BETWEEN ONSET AND DEATH several years 24 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) advanced osteoarthritis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) John, 1960, June 20, 1967, that (I) (we) last saw the deceased alive on June 20, 1967, and that death occurred at 12:30 M., from causes and on the date stated above									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) John		20f. (City or town) Emmitsburg		(County) Md.		(State) Carroll Co.	
21. I certify that (I) (this hospital) attended the deceased from John , 1960, to June 20, 1967 , that (I) (we) last saw the deceased alive on June 20, 1967 , and that death occurred at 12:30 M. , from causes and on the date stated above												
22a. SIGNATURE W. R. Cadle				22b. DATE SIGNED 6-20-67								
22c. PHYSICIAN'S NAME (Type) W. R. Cadle				22d. ADDRESS Emmitsburg, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 23, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Keysville Cemetery		23d. LOCATION (City or Town) Keysville, Md.		(County) Carroll Co.		(State)		
24. FUNERAL DIRECTOR Clarence E. Wilson				ADDRESS Emmitsburg, Md.		25a. REC'D BY REGISTRAR Minister Judge		25b. REGISTRAR'S SIGNATURE JUN 23 1967				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08146

08160

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 200 Thomas Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CLARA	Middle MYRTLE	Last GREENWALD	4. DATE OF DEATH	Month June	Day 3,	Year 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1889	9. AGE (In years at birthday) 78	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Feagaville, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME James Greenwald				14. MOTHER'S MAIDEN NAME Mary Measel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 220-30-9759		17. INFORMANT Miss Nora Jane Deater		Address 200 Thomas Ave. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bronchopneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Cerebral Infarction DUE TO (c) Cerebral Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Healed Cerebral Infarct - Epilepsy - Fractured Hip							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 5-28 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Frederick (County) Frederick (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Robert J. Thomas</i>							
EXAMINER'S NAME (Type) Robert J. Thomas		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-6-1967		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION (City or Town) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Maryland		25a. REC'D. BY REGISTRAR DATE JUN 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08161

CERTIFICATE OF DEATH

08147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elizabeth City				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 617 Biggs Avenue				d. STREET ADDRESS				
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Joseph	Middle John	Lost Harrell	4. DATE OF DEATH	Month June	Day 24	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1900	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire Insurance Rep.			10b. KIND OF BUSINESS OR INDUSTRY Insurance	11. BIRTHPLACE (County & State, or foreign country) Speed, North Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph John Harrell				14. MOTHER'S MAIDEN NAME Deborah Harrell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 241-28-3795		17. INFORMANT Address Mrs. Richard Kruse 617 Biggs Ave. Fred. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May , 1967, to June 24 , 1967 that (I) (we) last saw the deceased alive on JUNE 23 , 1967, and that death occurred at 150 P.M. from causes and on the date stated above.								22b. DATE SIGNED 6/24/67
22a. SIGNATURE A. Austin Pearre, Jr.		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Dr. A. Austin Pearre, Jr.		22d. ADDRESS M.D. 804 Toll House Avenue Fred. Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL Memory Gardens Cemetery		23d. LOCATION (City or Town) (County) (State) Elizabeth City, N. Carolina		
24. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge		
DATE JUN 27 1967								

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

M
State Department of
Health

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.S. and 3-10. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with him. Page 5 may be retained for your files.

08162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08148

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Hrs		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural New Market	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mae		First Ellen	Middle Herbert
4. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF DEATH Feb 6, 1931		9. AGE (In years lost birthday) yrs. 36	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooks Helper		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Clarence Weedon		14. MOTHER'S MAIDEN NAME Effie Naylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-2009028	17. INFORMANT Address James Brown Rt 1 Mt Airy, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH INTRACEREBRAL HEMORRHAGE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Robert J. Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert J. Thomas M.D.		22. DATE SIGNED Frederick 9/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St Pauls Church
24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Maryland		25a. REC'D BY REGISTRAR DATE JUN 14 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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subiect

social not family

etc

subiect

area of 1.0

household

Latino, Latino & non-Latino

etc

decade

etc

05 female child

adult female

husband

non-family

adult male

toilet area

household

5 area of 1.0 household etc

neighborhood

adult male household etc

x

x

x

71-16

adult female

adult female

5 age etc

6 sex etc

7 neighborhood

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13

08163

CERTIFICATE OF DEATH

08149

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>Care</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS <i>9 E. Potomac St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Ida</i>	Middle <i>Minnie</i>	Last <i>Himes</i>
4. DATE OF DEATH Month <i>June</i>	Month <i>9</i>	Day <i>1967</i>	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/15/84</i>
9. AGE (In years last birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during time of death, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Kentucky</i>	12. CITIZEN OF WHAT COUNTRY? <i>US</i>
13. FATHER'S NAME <i>Everitt Alley</i>	14. MOTHER'S MAIDEN NAME <i>Millie (unknown)</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>216-32-8229</i>	17. INFORMANT <i>Alma Parsons</i>	Address <i>Brunswick, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>GERIATRIC</i> DUE TO <i>Fracture of neck</i> 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH: <i>1 yr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fractured right hip</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell at home</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>6/26 1967</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Brunswick Fred. Md</i>
21. I certify that (I) (this hospital) attended the deceased from <i>4/22 1967</i> to <i>6/9 1967</i> that (I) (we) last saw the deceased alive on <i>6/8 1967</i> and that death occurred at <i>12 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert H. P. Igren</i>		22b. DATE SIGNED <i>6/9/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert H. P. Igren</i>	22d. ADDRESS <i>Prob Bldg Frederick Md</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6/11/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Knoxville Cemetery Brunswick Md.</i>	23d. LOCATION (City or Town) (County) (State) <i>Knoxville Md.</i>
24. FUNERAL DIRECTOR <i>Teete Funeral Home</i>	25. REG'D BY REGISTRAR DATE <i>JUN 14 1967</i>	26. REGISTRAR'S SIGNATURE <i>Charles J. George</i>	

1980

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08164

CERTIFICATE OF DEATH

08150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Monocacy Hall Nursing Home			d. STREET ADDRESS 1207 Fairview Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Oscar William Keyser			First Oscar	Middle William	Last Keyser	4. DATE OF DEATH June 10-1967	Month June	Day 10	Year 1967		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Sept. 17-1892			9. AGE (In years birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-			10b. KIND OF BUSINESS OR INDUSTRY Petroleum Distrib-			11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Wm. Frederick Keyser			14. MOTHER'S MAIDEN NAME Adella E. Stull								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 214-10-2472			17. INFORMANT Mrs. May F. Keyser-1207 Fairview Ave,			Address Frederick, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Sigmoid colon DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1963 to June 10, 1967 , that (I) (we) last saw the deceased alive on June 9, 1967 , and that death occurred on June 10, 1967 A.M., from causes and on the date stated above.											
22a. SIGNATURE Ronald L. Thomas			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED June 10-1967		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS Professional Bldg.-Frederick, Md. 21701								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13-1967		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701				
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son-- Frederick, Md. 21701			ADDRESS Whitmore			25b. REGISTRAR'S SIGNATURE DATE JUN 15 1967			25c. REGISTRAR'S SIGNATURE Charles Judge		

02131

CHARGE TO READER

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AGENCY

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WORCESTER HILL MURKIN HOME

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HISTORICAL CO., INC.

POLITICAL HISTORY

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THE HISTORY OF THE UNITED STATES OF AMERICA

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PROFESSOR ELLIOTT

REF ID: 0000
BIOGRAPHY OF

REF ID: 0000
JULY 15-1902 AGREEABLE TO OWNER

REF ID: 0000
REF ID: 0000
REF ID: 0000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

08166

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08151

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

NO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDRICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASH.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDRICK		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FREDRICK MEMORIAL Hosp.		d. STREET ADDRESS 2219 BONNIE BRIAR LANE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CASPER ELLSWORTH KIGHT		First	Middle
		Last	4. DATE OF DEATH JUNE 22 1967
S. SEX M	6. COLOR OR RACE WW	7. MARRIED WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 8, 1926
9. AGE (In years last birthday) 41 yrs.		9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10. DO. USUAL OCCUPATION (Give kind of work done during last 6 months of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	11. BIRTHPLACE (State or foreign country) PIEDMONT W.VA. U.S.A.
13. FATHER'S NAME CASPER E. KIGHT		14. MOTHER'S MAIDEN NAME KIRA FRYE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 235-30-0098	17. INFORMANT THEODORE KIGHT
		Address Frostburg	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Fractured skull			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Crushed chest	
20e. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) six car collision	
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. 6-22-67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20f. (City or town) (County) (State) Mr. Frederick Frederick - Md.	
ACTUAL SIGNATURE Robert J. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Rosecr J. THOMAS, M.D.	
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/67	23c. NAME OF CEMETERY OR CREMATORIAL PHILIPS CEM. WESTERN PORT, MD
24. FUNERAL DIRECTOR W.T. Harcourt Hosp. Md		23d. LOCATION (City or Town) (County) (State) DATE JUN 26 1967	25a. REC'D BY REGISTRAR Charles Judge
		25b. REGISTRAR'S SIGNATURE	

60130

should be rebuilt
and repaired

John T. Kelly
John T. Kelly

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10
08165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10
08152

1. PLACE OF DEATH a. COUNTY FREDRICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASH.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDRICK		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FREDRICK MEMORIAL HOSP.		e. STREET ADDRESS 2219 BONNIE BRIAR LANE HAGERSTOWN	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SARAH ELAINE KIGHT		First	Middle
4. DATE OF DEATH JUNE 22 1967	Month	Doy	Year
5. SEX FM	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 29, 1924
9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESWOMAN		10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
11. BIRTHPLACE (State or foreign country) WESTERN PORT, MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY MO.	
13. FATHER'S NAME WILLIAM F. KOOKEN		14. MOTHER'S MAIDEN NAME LAURA BAILEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-16-6560	
17. INFORMANT MARY A. SHIREY CUMBERLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest, Lacerated lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Fractured skull	
		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) six car collision on highway	
20c. TIME OF INJURY Month, Day, Year Hour 2:30 p.m. 6-22 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Mr. Frederick - Frederick - Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 6-22-67	
ACTUAL SIGNATURE Robert J. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) ROBERT J. THOMAS, M.D.		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/26/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Philos Cemetery		23d. LOCATION (City or Town) (County) (State) WESTERN PORT MD.	
24. FUNERAL DIRECTOR W. T. Norment, Hdg. Inc.		25a. REC'D BY REGISTRAR DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judd	

80100

the next day
and another

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in the same place

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08167 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Item #2,11 From Birth Cert.

CERTIFICATE OF DEATH

08153

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Baby Boy	Middle King	Last 6
4. DATE OF DEATH Month 6	Day 23	Year 1967	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIOOWED <input type="checkbox"/> DIVORCEO <input type="checkbox"/>	8. DATE OF BIRTH 6/23/67
9. AGE (in years last birthday) yrs.	10. KIND OF BUSINESS OR INDUSTRY Fred. Co., Md.	11. BIRTHPLACE (County & State, or foreign country) Fred. Co., Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Mack Arthur Rowe	14. MOTHER'S MAIDEN NAME Shirley King		
15. WAS DECEASED EVER IN U.S. ARME OF FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diseasity</i> 776X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>BW 2 lb 1 1/2 oz</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>6/23</i> , 1967, to <i>6/23</i> , 1967, that (I) (we) last saw the deceased alive on <i>6/23</i> , 1967 and that death occurred at <i>6 1/2 M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>J. Fred Baker</i>		22b. DATE SIGNED <i>6/23/67</i>	
22c. PHYSICIAN'S NAME (Type) J. FRED BAKER MD.		22d. ADDRESS <i>Frederick, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-24-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Col Cemetery		23d. LOCATION (City, town or county) Lorettoville Virginia (State)	
24. FUNERAL DIRECTOR Feele Funeral Home		25a. REC'D BY REGISTRAR Charles Judge DATE JUN 27 1967	
7-194347		25b. REGISTRAR'S SIGNATURE	

60113.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Thurmont rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				50 yrs.		Thurmont rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Own Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day Year
Orestes F. Leatherman					JUNE	22	1967
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years since birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
male		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-13-1878	88 yrs.	Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
Farmer		Own Farm		Maryland			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Daniel Leatherman		Josephine Curtis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		214-36-0048		John D. Leatherman		Thurmont Md. RD1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease DUE TO 10+ yrs (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 22 June, 1967, that (I) (we) last saw the deceased alive on 17 June 1967, and that death occurred at 2:55 PM, from the causes and on the date stated above.		22b. DATE SIGNED 22c. SIGNATURE Charles H. Conley, Jr. 22d. ADDRESS CHARLES H. CONLEY, JR. Professional Bldg. Frederick, MD					
22c. PHYSICIAN'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL Blue Ridge Cemetery 23d. LOCATION (City, town or county) (State) Burial 6-25-67 Thurmont Fred. Co. Md.					
24. FUNERAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Raymond E. Creager Thurmont, Md. Date JUN 27 1967 Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

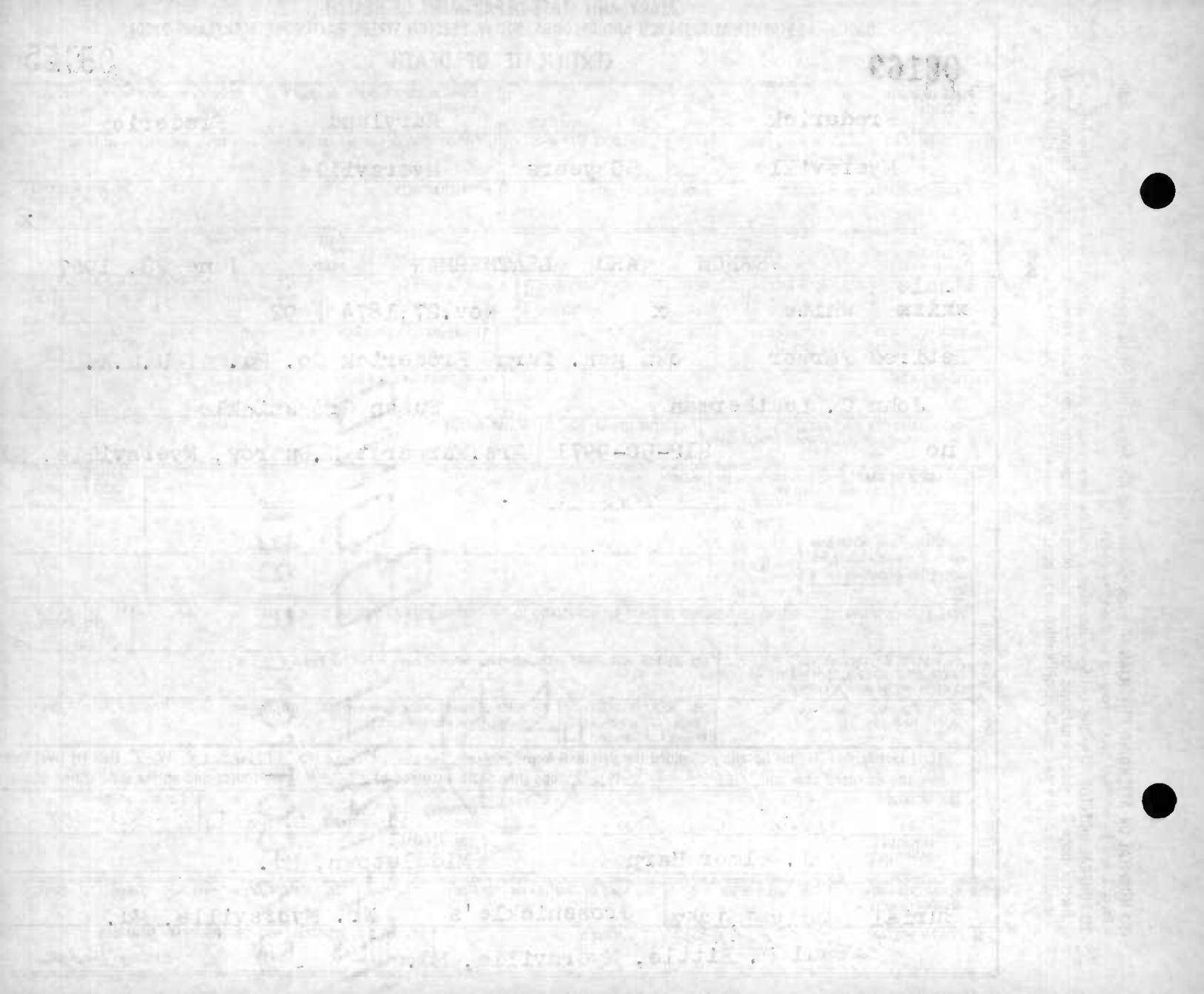
11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08163

CERTIFICATE OF DEATH

08155

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Frederick MARYLAND		Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville				
c. LENGTH OF STAY IN lb 50 years		d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First VERNON	Middle WARD	Last LEATHERMAN	4. DATE OF DEATH June 28, 1967	Month Day Year
5. SEX male <input checked="" type="checkbox"/> white		6. COLOR OR RACE <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED B. DATE OF BIRTH Nov. 27, 1874		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY own gen. farm		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Leatherman		14. MOTHER'S MAIDEN NAME Susan Grossnickle				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		16. SOCIAL SECURITY NO. 212-50-9971		17. INFORMANT Mrs. Margaret N. Dutrow, Myersville, Md.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4231 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. stating the underlying cause last.		Cardiac Insufficiency		INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO		Generalized Arterio-Sclerosis				
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from June 6, 1967, to June 28, 1967, that (I) (we) last saw the deceased alive on June 24, 1967, and that death occurred at M, from causes and on the date stated above.						
22a. SIGNATURE <i>J. Elmer Harp</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6-30-67	
22c. PHYSICIAN'S NAME (Type) J. Elmer Harp		22d. ADDRESS Middletown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Grossnickle's	23d. LOCATION (City or Town) Nr. Myersville, Md.	(County)	(State)
24. FUNERAL DIRECTOR <i>Paul F. Bittle</i>		ADDRESS Paul F. Bittle, Myersville, Md.	25a. REC'D BY REGISTRAR JUL 3 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08170

CERTIFICATE OF DEATH

08156

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Leoma		First Frederick	Middle Lincks
4. DATE OF DEATH Month 6	Month 29	Doy 19	Year 67
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVDRCD <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1899
9. AGE (In years lost birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis H. Lincks		14. MOTHER'S MAIDEN NAME Lovetta Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-05-6955 Thurston Lincks	
17. INFORMANT Thurston Lincks		Address Knoxville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Anemia pectoris			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Taureus hepatomegaly			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6/26/62, 19
20f. (City or town) 6/29/62, 19		(County) 6/29/62, 19	
(State) 6/29/62, 19			
21. I certify that (I) (This hospital) attended the deceased from 6/26/62, 19 to 6/29/62, 19 , that (II) (we) last saw the deceased alive on 6/28/62, 19 , and that death occurred at 4:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE A. Austin Pearce, M.D.		22b. DATE SIGNED 6/29/67	
22c. PHYSICIAN'S NAME (Type) A. Austin Pearce, M.D.		22d. ADDRESS Frederick Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/1/67	23c. NAME OF CEMETERY OR CREMATORIAL Park Heights Cemetery
24a. FUNERAL DIRECTOR Fest Funeral Home		23d. LOCATION (City or Town) Brunswick Maryland	
		(County) Brunswick Maryland	
		(State) Brunswick Maryland	
RECD BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE JUL 3 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08171

CERTIFICATE OF DEATH

08157

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick (New Addition)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	d. STREET ADDRESS 733 East Potomac Street
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) New Addition		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arrah Mae Lloyd	First Arrah	Middle Mae	Last Lloyd
4. DATE OF DEATH Month 6	Day 3	Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1/27/04	9. AGE (In years last birthday) 63	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria cook (Elementary School)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Wilt	14. MOTHER'S MAIDEN NAME Lizzie Frye	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 214-34-2284	17. INFORMANT James M. Lloyd, Falling Water, W.Va.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA - rt. BREAST		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
170 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
DUE TO (b) GENERALIZED metastasis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Brunswick
20f. (City or town) Brunswick		(County) Maryland	(State) MD
21. I certify that (I) (this hospital) attended the deceased from 1-1-1967 to 6-3-1967 , that (I) (we) last saw the deceased alive on 6-3-1967 , and that death occurred at Brunswick M. from causes and on the date stated above.			
22a. SIGNATURE Charles E. Pruitt, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. Charles E. Pruitt, M.D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Brunswick, Maryland
22b. DATE SIGNED 6-5-67			
23a. BURIAL, CREMATION, REMOVALS (specify) 6/6/67		23b. DATE THEREOF 6/6/67	23c. NAME OF CEMETERY OR CREMATORIAL Park Heights Cemetery
23d. LOCATION (City or Town) Brunswick		(County) Maryland	(State) MD
24. FUNERAL DIRECTOR Feeley Funeral Home - Brunswick Maryland		ADDRESS Brunswick	25a. REC'D BY REGISTRAR DATE JUN 8 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

87130

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1990-01-10 10:00:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08158

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
Frederick MARYLAND		a. STATE Maryland	b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 1963						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Md. Odd Fellows Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Mary	Middle H.					
4. DATE OF DEATH		Month June	Day 27-	Year 1967				
5. SEX		6. COLOR OR RACE Female White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18-1887	9. AGE (in years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months Deys	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Smith		14. MOTHER'S MAIDEN NAME Laura Burley						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT 213-07-9116D Md. Odd Fellows Home- Frederick, Md. 21701		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 332X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. } (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1 Month 10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from June 18, 1967, to June 27, 1967, that (I) (we) last saw the deceased alive on June 26, 1967, and that death occurred at 12:05A.M. from the causes and on the date stated above.								
22e. SIGNATURE B.O.Thomas Jr.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED June 27-67		
22c. PHYSICIAN'S NAME (Type) Dr. B.O. Thomas, Jr.		22d. ADDRESS Prof. Bldg.-Frederick, Md. 21701						
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 30-1967	23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore- Md.			
24 FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son		ADDRESS Frederick, Md. 21701	25e. REC'D BY REGISTRAR DATE 30 JUN 1967					
			25b. REGISTRAR'S SIGNATURE Charles Judge					

A20:SE

X
Dr. H. G. Powers, Jr. Dr. H. G. Powers, Jr.
Brooklyn, New York, N.Y. 11201
June 30-1943 Oak Park Cemetery
Baltimore, Md. Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-10.

O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial cremation or removal and in any event within 72 hours after death. This form may be retained for your files.

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08173

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08159

I. PLACE OF DEATH o. COUNTY Frederick				MARYLAND															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Years																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA- Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)		First Wm.	Middle Graden	Last Markoe	4. DATE OF DEATH Sept. 14-1908	Month June	Day 6-	Year 19 67											
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14-1908	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min. 										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman				10b. KIND OF BUSINESS OR INDUSTRY Tailoring Co.				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Wm. G. Markoe																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No				16. SOCIAL SECURITY NO. 214-10-3061				17. INFORMANT Miss Betty Lou Markoe-227 E. 4th St.-											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. H201 (b) Coronary artery occlusion DUE TO (c) Arteriosclerotic cardiovascular disease										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 		(County) 		(State) 									
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED June 6-1967									
ACTUAL SIGNATURE <i>Robert J. Thomas</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Frederick, Md.									
EXAMINER'S NAME (Type) Dr. Robert J. Thomas		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial								23b. DATE THEREOF June 9-1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Olivet Cemetery		23d. LOCATION (City or Town) Frederick, Md.		(County) 21701		(State) 	
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son		25a. REC'D BY REGISTRAR Charles Judge								25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 14 1967							

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08174

CERTIFICATE OF DEATH

08160

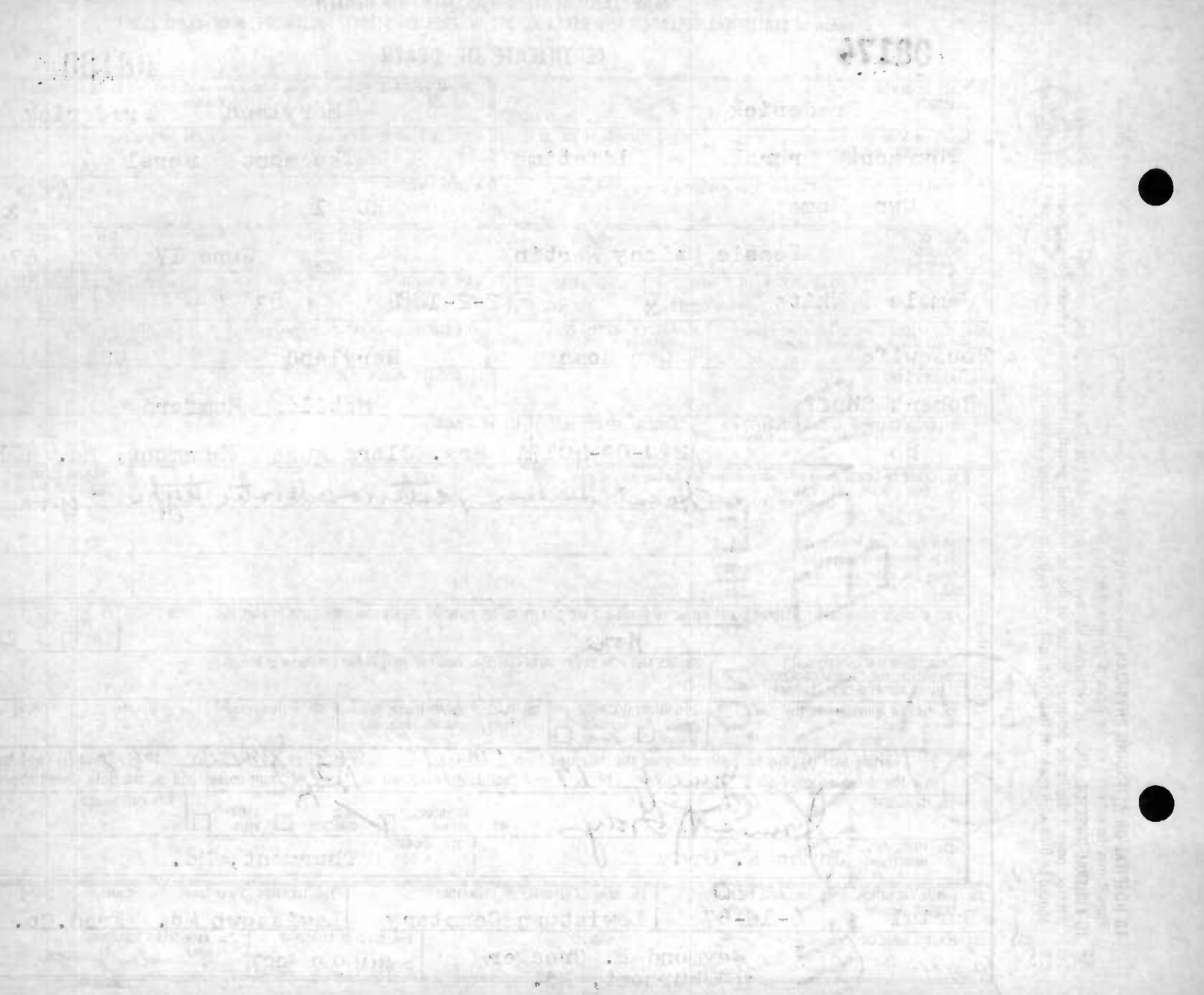
1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove far back papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d. STREET ADDRESS RD 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lessie Daisey Martin		First Lessie	Middle Daisey
Last Martin		4. DATE OF DEATH June 17	Month Day Year 19 67
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-2-1884		9. AGE (In years at birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Shuff		14. MOTHER'S MAIDEN NAME Matilda Mumford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-4017A	
17. INFORMANT Mrs. Clara Fuss		Address Thurmont, Md. RD1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease, arteriosclerotic type DUE TO 4200		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Thurmont, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 1, 1963 , to June 16, 1967 , that (I) (we) last saw the deceased alive on June 16, 1967 , and that death occurred at Thurmont, Md. from causes and on the date stated above.			
22a. SIGNATURE James K. Gray		22b. DATE SIGNED June 19, 1967	
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-67	23c. NAME OF CEMETERY OR CREMATORIAL Lewistown Cemetery
23d. LOCATION (City or Town) Lewistown Md.		(County) Fred. Co.	
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR JUN 22 1967
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1040 30 MAR 1963

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

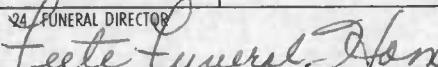
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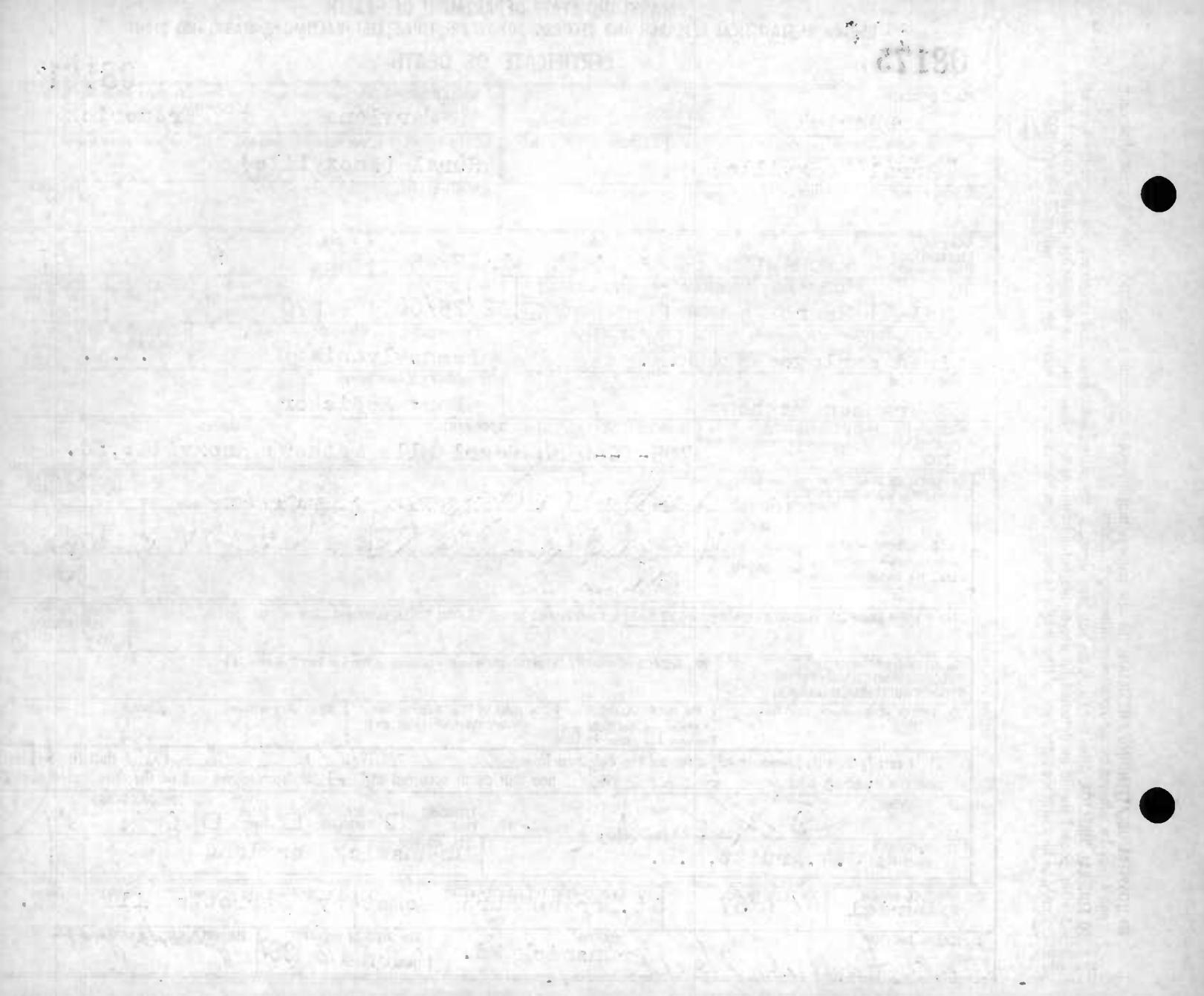
CERTIFICATE OF DEATH

08161

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Knoxville)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Knoxville)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle FRANCIS	Last MATHEWS	4. DATE OF DEATH	Month 6	Day 6	Year 1967
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/88		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired employee B&O R.R.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Branson Mathews			14. MOTHER'S MAIDEN NAME Mary Redickor			Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 705-10-0544		17. INFORMANT Pearl Ella Mathews Knoxville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H42X DUE TO High blood pressure INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) Arteriosclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6-5-1967 to 6-6-1967 , that (I) (we) last saw the deceased alive on 6-5-1967 , and that death occurred at C.A.M. from causes and on the date stated above.								
22o. SIGNATURE 								
22c. PHYSICIAN'S NAME (Type) C.E. Pruitt, M.D.		22d. ADDRESS Brunswick Maryland						
23a. BURIAL CREMATION REMOVAL Burial		23b. DATE THEREOF 6/10/67		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Moriah Church Cemetery		23d. LOCATION (City or Town) Garrett's Mill County Md. (State)		
24. FUNERAL DIRECTOR 		ADDRESS Brunswick Md.		25a. RECD BY REGISTRAR DATE JUN 12 1967		25b. REGISTRAR'S SIGNATURE 		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08176

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08162

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 14 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Frederick Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Lawrence McCloud		First James	Middle Lawrence
4. DATE OF DEATH June 27 1967		Last McCloud	Month Day Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> <input type="checkbox"/>
8. DATE OF BIRTH 9-26-1921		9. AGE (In years last birthday) yrs. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooks Helper		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) District of Columbia U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles D. McCloud		14. MOTHER'S MAIDEN NAME Isabelle Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 578-20-1483	
17. INFORMANT Charles McCloud		Address Washington D.C. 502 25th Place N.E.C.	
18. CAUSE OF DEATH (Enter only one cause per line for part (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic Bronchitis (b) DUE TO (c) DUE TO Carcinoma of Larynx INTERVAL BETWEEN ONSET AND DEATH 161X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Fred. Md.	
EXAMINER'S NAME (Type) Robert J. Thomas		22. DATE SIGNED 6-27-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Fairview
24. FUNERAL DIRECTOR C.E. Hicks, 111		23d. LOCATION (City or Town) (County) (State) Frederick Fred. Md	
		25a. REC'D BY REGISTRAR JUN 29 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
		DATE	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

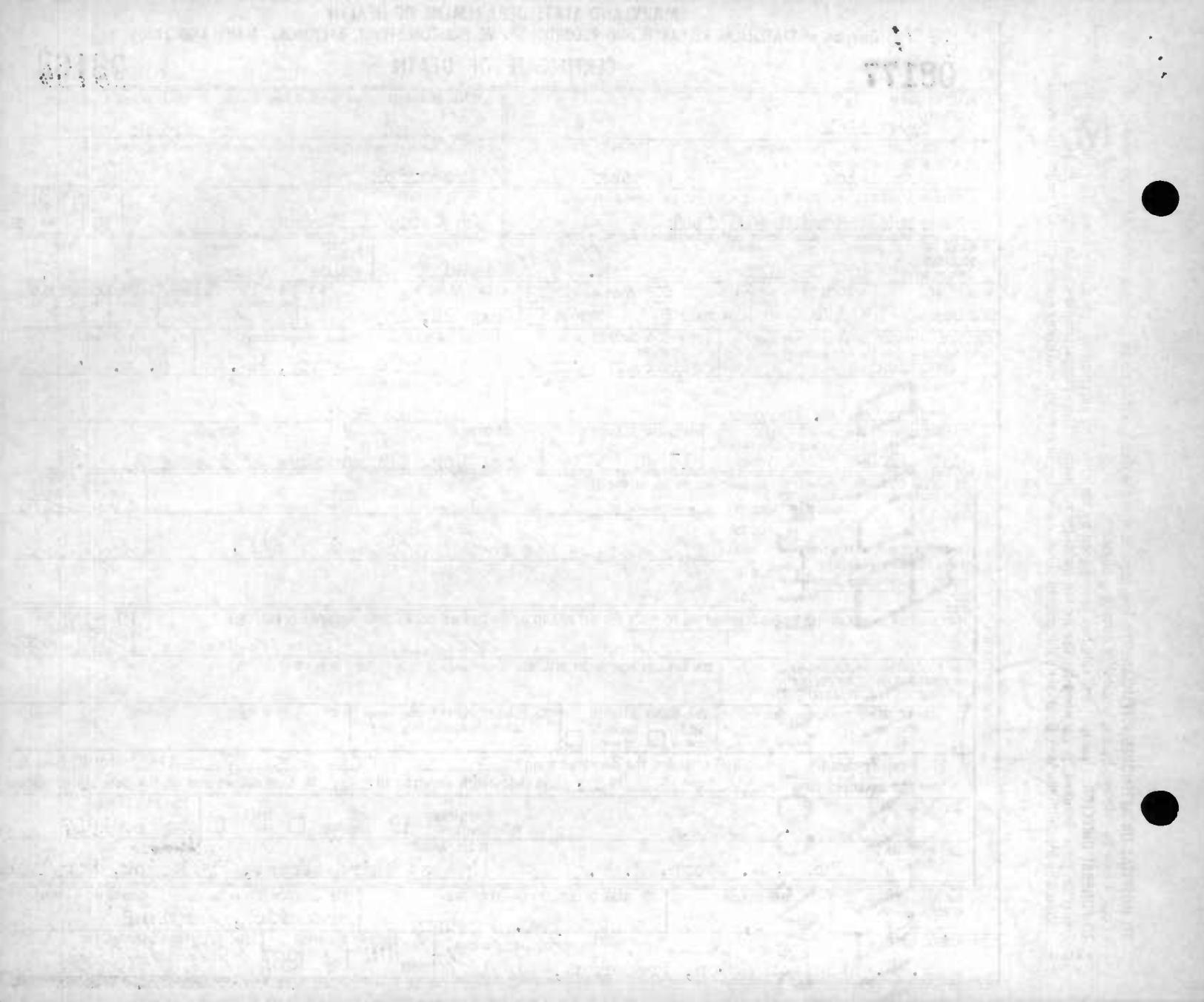
08177

CERTIFICATE OF DEATH

08163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 104 Carroll Parkway				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) CHARLES		First H.	Middle MERCER	Lost	4. DATE OF DEATH June 5, 1967	Month June	Doy 5	Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1892	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Petroleum Business			11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. Mercer				14. MOTHER'S MAIDEN NAME Lavinia Poole						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 218 30 9333A			17. INFORMANT Mrs. Cora Mercer (Same as item # 2)			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerotic Heart Dis DUE TO { (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 months										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diabetes Mellitus, Bronchopneumonia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred while at work							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Apr 3, 1967 , to Jun 5, 1967 , that (I) (we) last saw the deceased alive on Jun 5, 1967 , and that death occurred at 8014 N M, from causes and on the date stated above.										
22o. SIGNATURE Thomas E. Stone				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Jun 6, 1967			
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D.				22d. ADDRESS 4 West Third Street, Frederick, Maryland						
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 8, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Frederick, Maryland			
24. FUNERAL DIRECTOR Donald J. Etchison				ADDRESS M. R. Etchison & Son, Frederick, Maryland		25o. REC'D BY REGISTRAR DATE JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



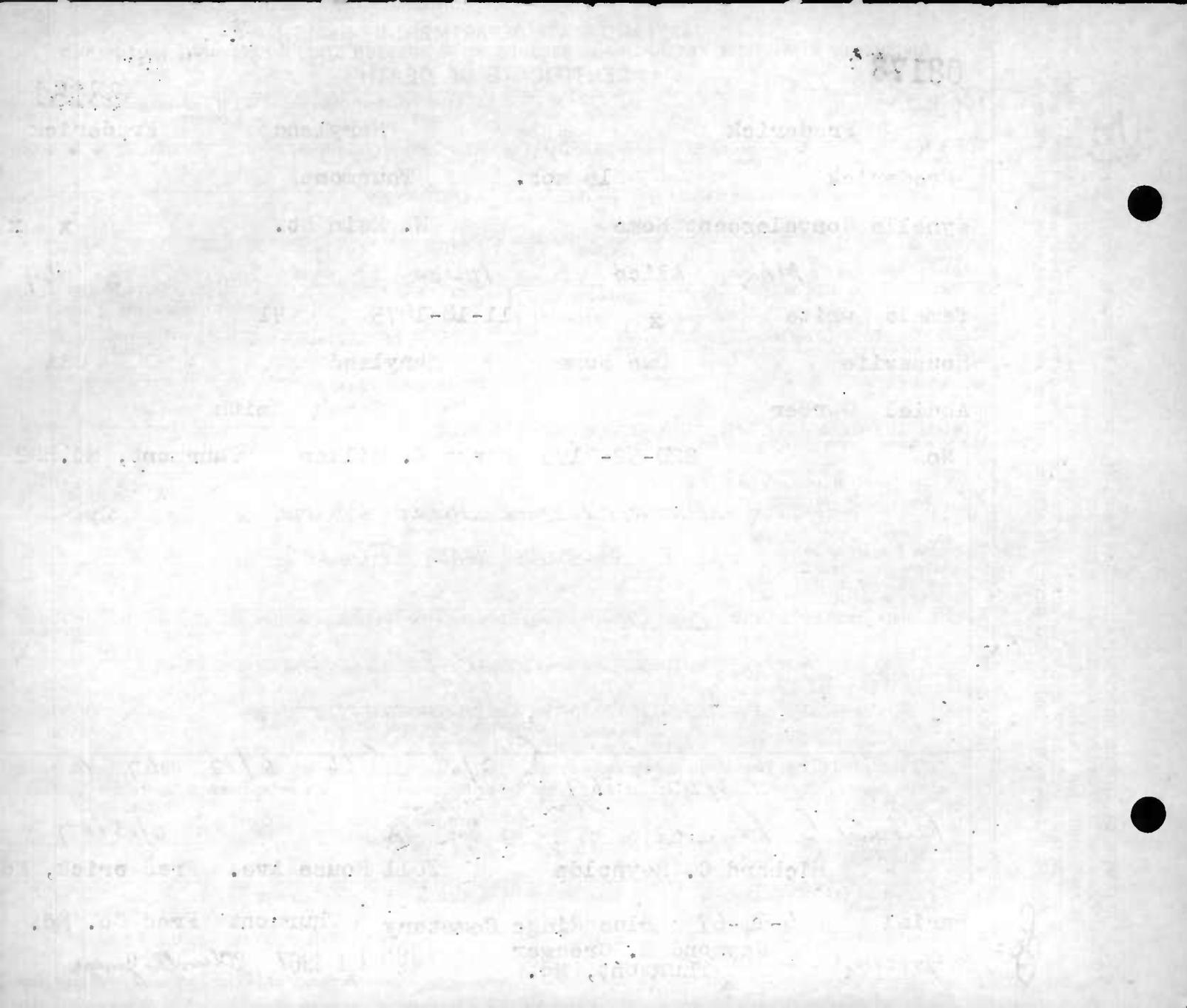
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08173 08154

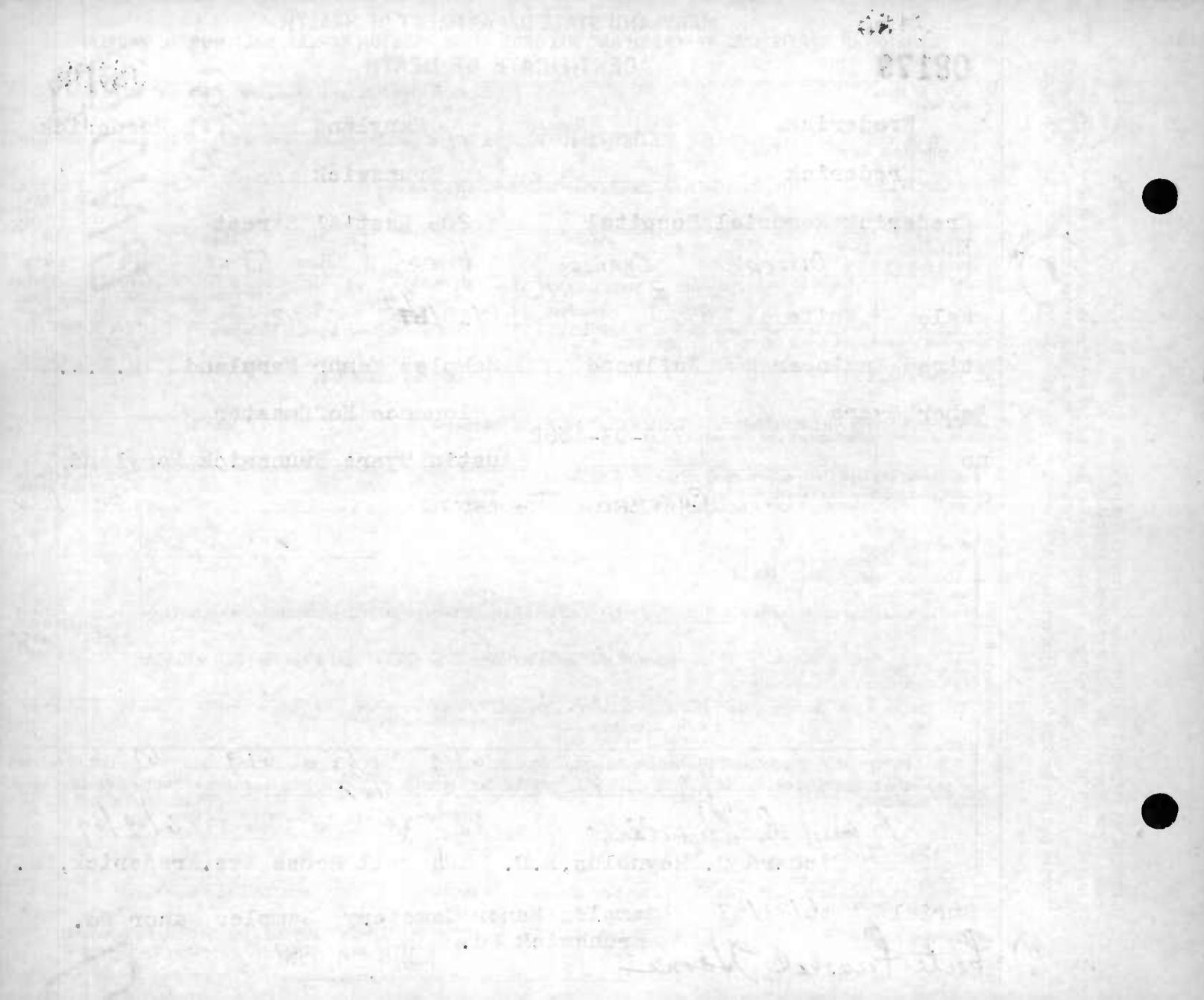
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours afterPage 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Frederick		16 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Wynelle Convalescent Home		90	
3. NAME OF DECEASED First MIDDLE LAST		4. DATE OF DEATH Month Day Year	
MARY Alice MILLER		JUNE 12 1967	
5. SEX		6. COLOR OR RACE	
female white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (in years last birthday) IF UNOER 1 YEAR IF UNOER 2 HRS	
11-18-1875		91 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Own Home	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Abdiel Garber		Sarah Smith	
15. WAS DECEASEE EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT Address	
		Harry O. Miller Thurmont, Md. RD2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC HEART DISEASE</i>			
4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
20g. (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>2/5</i> , 19 <i>66</i> , to <i>6/12</i> , 19 <i>67</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>3/22</i> 19 <i>67</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard C. Reynolds</i>			
22b. DATE SIGNED <i>6/13/67</i>			
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Richard C. Reynolds		22d. ADDRESS Toll House Ave. Fredrick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		23c. NAME OF CEMETERY OR CREMATORIUM	
6-14-67		23d. LOCATION (City, town or county) (State)	
		Thurmont Fred Co. Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR ADDRESS	
Raymond E. Creager Thurmont, Md.		JUN 14 1967	
		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08179				08165							
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Brunswick							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 205 East A Street							
e. NAME OF DECEASED (Type or print) OLIVER CHARLES MYERS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
f. SEX Male White				f. DATE OF DEATH JUNE 19 1967							
g. COLOR OR RACE White				g. DATE OF BIRTH 8/18/64							
h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				h. AGE (In years last birthday) 72 yrs.							
i. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer B&O Railroad				i. 11. BIRTHPLACE (County & State, or foreign country) Samples Manor Maryland							
j. 13. FATHER'S NAME Asher Myers				j. 12. CITIZEN OF WHAT COUNTRY? U.S.A.							
k. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)				k. 16. SOCIAL SECURITY NO. 719-03-1002 l. 17. INFRMANT							
l. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				m. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> n. INTERVAL BETWEEN ONSET AND DEATH One hour							
m. MEDICAL CERTIFICATION											
o. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				o. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
p. 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				q. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		r. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 804 Toll House Ave. Frederick, Md.		s. 20f. (City or town) (County) (State)			
t. 21. I certify that (I) (this hospital) attended the deceased from 6/19 , 1967, to 6/19 , 1967, that (I) (we) last saw the deceased alive on 6/19 , 1967, and that death occurred at 6/20 , 1967, M, from the causes and on the date stated above.				u. 22a. SIGNATURE Richard C. Reynolds , M.D.							
v. 22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M.D.				w. 22b. DATE SIGNED 6/19/67		x. 22d. ADDRESS 804 Toll House Ave. Frederick, Md.					
y. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				z. 23b. DATE THEREOF 6/21/67		aa. 23c. NAME OF CEMETERY OR CREMATORIAL Samples Manor Cemetery		ab. 23d. LOCATION (City, town or county) (State) Samples Manor Md.			
ac. 24. FUNERAL DIRECTOR Fleete Funeral Home				ad. ADDRESS Brunswick Md.		ae. 25a. REC'D BY REGISTRAR DATE JUN 20 1967		af. 25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08180		08166	
1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Doubts</u>	
c. LENGTH OF STAY IN lb <u>8 days</u>		d. STREET ADDRESS <u>Box 53- Doubts</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>Phillip</u> Middle <u>More</u> Surname <u>Philmore Newman, Jr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-3-1898</u>	
9. AGE (In years lost, birthday) <u>65 yrs.</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Philmore Newman, Sr</u>		14. MOTHER'S MAIDEN NAME <u>CORA WILLIAMS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-12-7161</u>	
17. INFORMANT <u>Earl F. Newman</u>		Address <u>York-Poresso Place</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic Heart Disease</u> DUE TO lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Coronary of live</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Frederick</u> (County) <u>Md</u> (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May 28</u> , 1967, to <u>June 6</u> , 1967, that (I) (we) last saw the deceased alive on <u>June 5</u> , 1967, and that death occurred at <u>4A</u> M. from causes and on the date stated above.		22b. DATE SIGNED <u>6 June 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		22d. ADDRESS <u>804 Toll House Ave Frederick, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-9-1967</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>MT Pleasant Church</u>		23d. LOCATION (City or Town) <u>Lucketts</u> (County) <u>VA</u> (State) <u>VA</u>	
24. FUNERAL DIRECTOR <u>C.E. Hicks III</u>		25a. ADDRESS <u>Frederick, Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REC'D BY REGISTRAR <u>JUN 8 1967</u>	

100-4010150

02150

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08181

CERTIFICATE OF DEATH

08167

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY - Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tenn. b. COUNTY Blount	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryville 793	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Mem. Hospital		d. STREET ADDRESS 214 Stanley St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Lamar		First Nuchols	Middle Lam
4. DATE OF DEATH Month June Day 19 Year 1967		Lost	5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 20, 1875		9. AGE (In years lost birthday) 91 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Banker		11. BIRTHPLACE (County & State, or foreign country) Maryville, Tenn.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Waters Nuchols		14. MOTHER'S MAIDEN NAME Mary Jane Broady	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 409-05-9797	17. INFORMANT Mr. James W. Hitch, Damascus, Md. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 3 WKS	
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE & PUL. EDema		DUE TO	
(c) ARTERIOSCLEROTIC HEART DISEASE		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CARCINOMA PROSTATE CARCINOMA BLADDER. ART. SCL GENERALIZG		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Frederick (County) Maryland (State) MD
21. I certify that (I) (this hospital) attended the deceased from 6/25 , 1967, to 6/15 , 1967, that (I) (we) last saw the deceased alive on 6/15 , 1967, and that death occurred at 7:00 M, from causes and on the date stated above.		22b. DATE SIGNED 6/19/67	
22c. PHYSICIAN'S NAME (Type) GILLEN F. MCADOO, MD		22d. ADDRESS 810 Folkhouse Ave Frederick, MD	22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 22, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Grove Baptist
24. FUNERAL DIRECTOR ADDRESS		25a. LOCATION (City or Town) Maryville, Tenn. (County) Tenn. (State) MD	
Olin L. Molesworth, Damascus, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE JUN 21 1967			

12100

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08182

CERTIFICATE OF DEATH

08169

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rural		c. LENGTH OF STAY IN 1b 35 years				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 5		d. STREET ADDRESS Route 5				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Fannie G. Phleeger		First Fannie	Middle G.			
3. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/27/1867			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home				
13. FATHER'S NAME Henry Gonso		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME Charlotte Kolb				
16. SOCIAL SECURITY NO. 219-54-2312		17. INFORMANT Ida Phleeger, Frederick, Md.	Address Route 5			
18. CAUSE OF DEATH (Enter only one cause per line) for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hour 5 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Middletown	(County) Maryland	(State) MD
21. I certify that (I) (this hospital) attended the deceased from 5/27/67 to 7/27/1967 , that (I) (we) last saw the deceased alive on 5/27 1967 , and that death occurred at Middletown M, from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. SIGNATURE James B Thomas		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Frederick, Md.
22c. PHYSICIAN'S NAME (Type) Dr. James B. Thomas		22d. ADDRESS Frederick, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/29/67	23c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery	23d. LOCATION (City or Town) Middletown, Fred.		(County) Maryland
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.		ADDRESS Gladhil Company, Middletown, Md.		25a. REC'D BY REGISTRAR JUL 3 1967	25b. REGISTRAR'S SIGNATURE Merle Judge	(State) MD

364180

JUN 19 1970

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08183

CERTIFICATE OF DEATH

08168

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		d. STREET ADDRESS same				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13 N. Maryland Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Marie	Middle Margaret	Last Rau	4. DATE OF DEATH	Month 6	Doy. 15	Year 1967		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/96	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Harpers Ferry W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Leo Bowler				14. MOTHER'S MAIDEN NAME Margaret Kain						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. None		17. INFORMANT Mary Agnes Willey			Address Baltimore Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Congestive Heart Failure DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR Disease								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19					20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) (County) (State)
21. I certify that (I) attended the deceased from 6-1-67 to 1967 , that (I) last saw the deceased alive on 6-1-67 , and that death occurred on 1967 P.M. from causes and on the date stated above.								22b. DATE SIGNED 6/16/67		
22a. SIGNATURE Robert J. Thomas			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22d. ADDRESS 812 Toll House Ave		
22c. PHYSICIAN'S NAME (Type) ROBERT J. THOMAS M.D.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/19/67		23c. NAME OF CEMETERY OR CREMATORIAL St. Peters Cemetery		23d. LOCATION (City or Town) Harpers Ferry W.VA.				
24. FUNERAL DIRECTOR Fleete Funeral Home		ADDRESS Brunswick, Md.		25a. REC'D BY REGISTRAR JUN 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08184

CERTIFICATE OF DEATH

08170

1. PLACE OF DEATH

a. COUNTY
Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Middleburg, Md. **FREDERICK** 15 yrs

c. LENGTH OF STAY IN lb

1 DAY

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Wd 200, WRGH, Ft Detrick, Md.

3. NAME OF
DECEASED
(Type or print)

First
JOSEPH

Middle

Last
ROSEBROCK

Month
June
Day
22
Year
1967

4. SEX

Male

6. COLOR OR RACE

Cauc

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

B. DATE OF BIRTH

Feb 4, 1922

9. AGE (In years
last birthday)

45 yrs.

IF UNDER 1 YEAR
Months Deys

IF UNDER 24 HRS.
Hours Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Soldier

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Queens, New York

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Henry Rosebrock

Emma Sassa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

Yes 1942 - 1965

16. SOCIAL SECURITY NO.

066 16 6398

17. INFORMANT

Jane G. Rosebrock Wife Middleburg, Md.

Address

IB. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial infarction

INTERVAL BETWEEN
ONSET AND DEATH

1 day

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
11 Hour a.m. June 22 1967

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Smith's Bakery Ladiesburg Frederick Md

21. I certify that (I) (this hospital) attended the deceased from 22 June 1967 to 23 June 1967, that (I) (we) last saw the deceased alive on 22 June 1967, and that death occurred at 13:20, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

A. C. ALEVIZATOS, Captain, MC

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
22 June 67

22d. ADDRESS

US Army Medical Unit, Ft Detrick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial June 26 1967

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

J. E. Myers Jr., mortimte, Md. 21151

25a. REG'D BY REGISTRAR

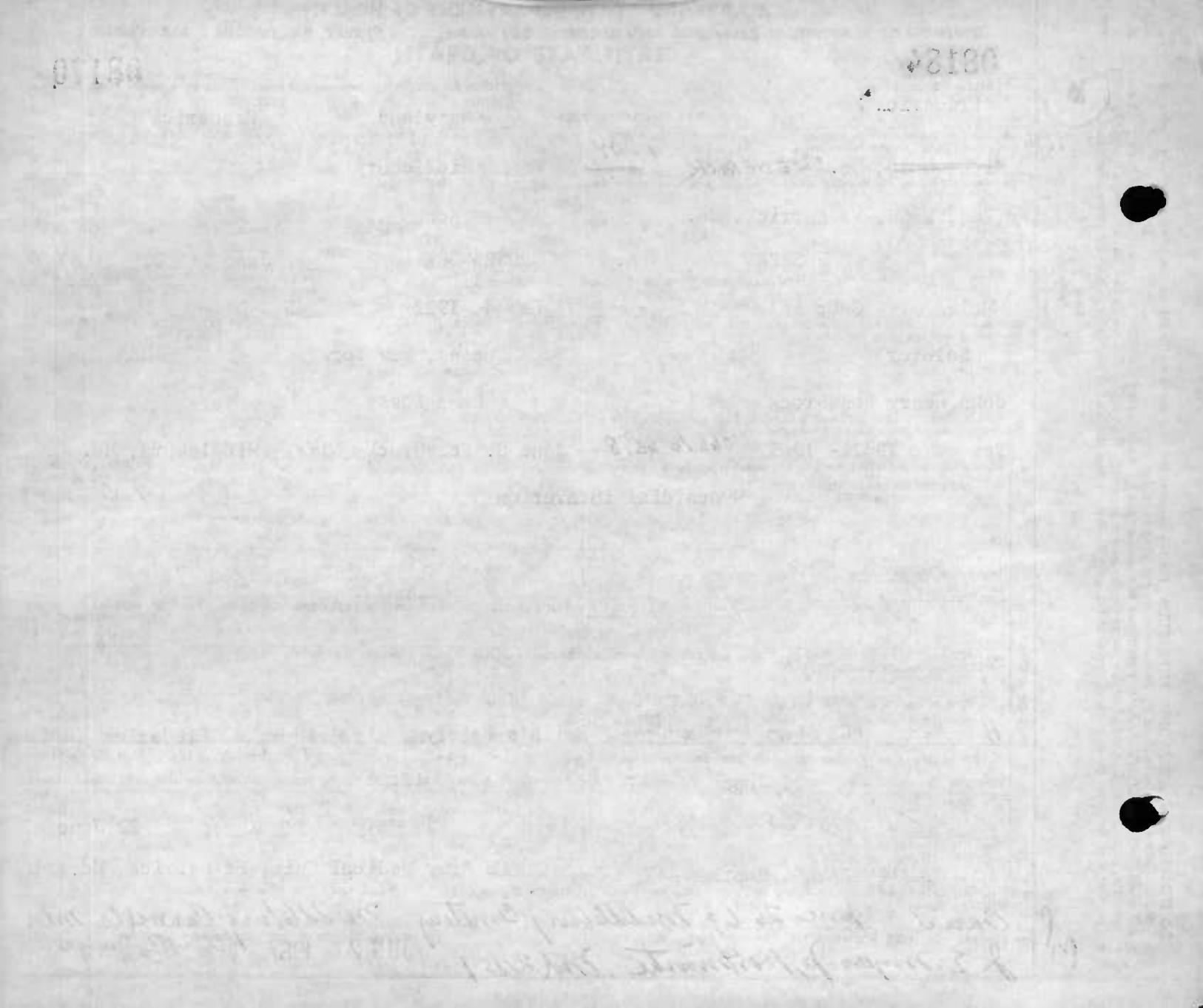
JUN 26 1967

DATE

25b. REGISTRAR'S SIGNATURE

Charles Judge

00124



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08185

CERTIFICATE OF DEATH

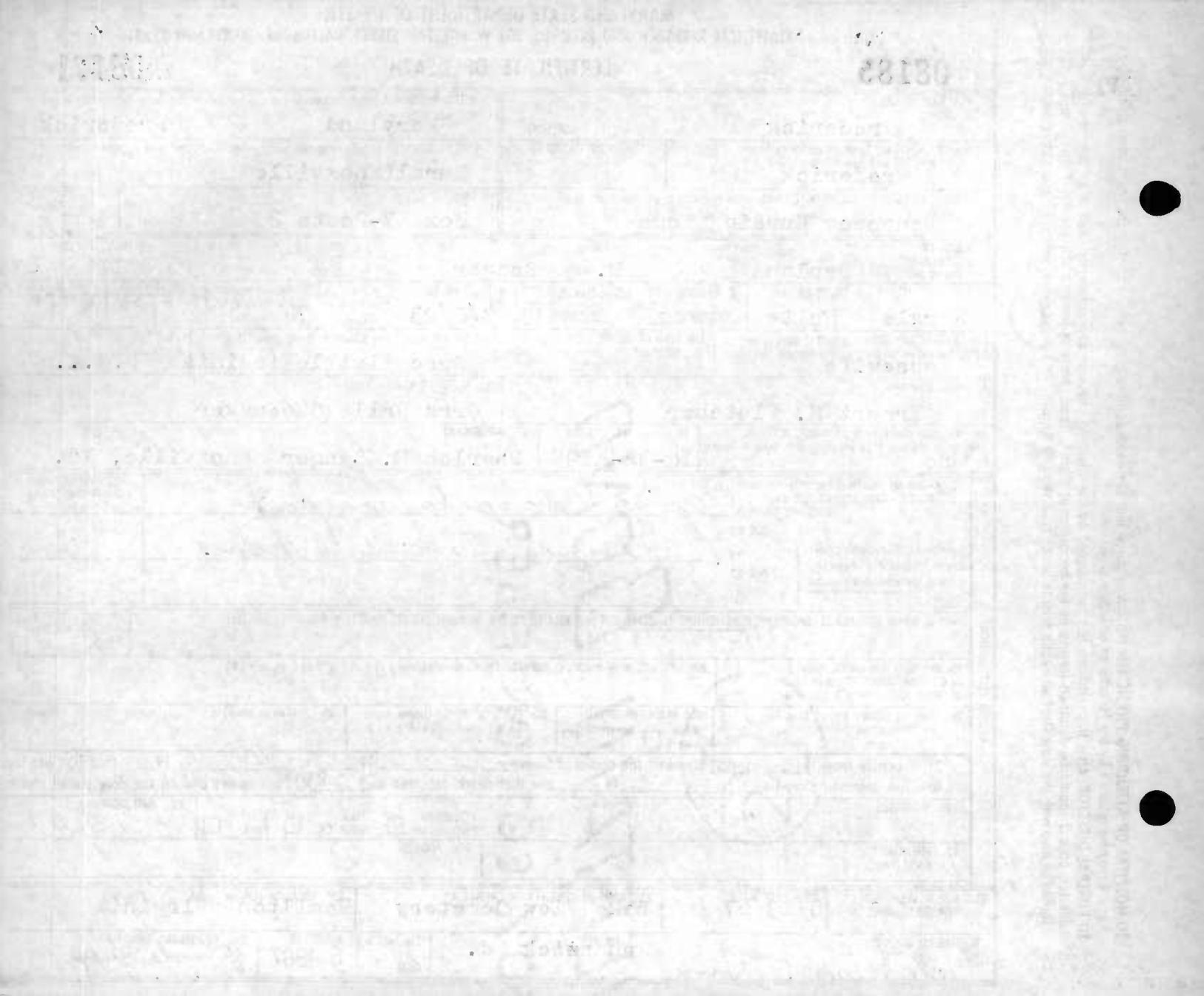
08171

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural(Knoxville)		d. STREET ADDRESS Box 57-Route 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Monocacy Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Beulah	Middle M.	Last Sanger	4. DATE OF DEATH	Month 6	Day II	Year 19 67		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> WIOOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/93	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Purcellville Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ernest F. Fletcher		14. MOTHER'S MAIDEN NAME Orra Belle Shoemaker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-32-4195		17. INFORMANT Address Charles E. Sanger Knoxville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident		DUE TO Arteriosclerotic vascular disease		INTERVAL BETWEEN ONSET AND DEATH 6 mos.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 		DUE TO 		DUE TO 		5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec , 19 66 , to June 14 , 19 67 , that (I) (we) last saw the deceased alive on June 11 , 19 67 , and that death occurred at 3:28 PM from causes and on the date stated above.									
22a. SIGNATURE LeRoy T. Davis		M.D. ATTENDING PHYS. <input type="checkbox"/> DIRECTOR		MED. STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/12/67			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
23a. BURIAL, CREMATION, REMAINS Reburial		23b. DATE THEREOF 6/13/67		23c. NAME OF CEMETERY OR CREMATORIAL Lake View Cemetery		23d. LOCATION (City or Town) (County) (State) Hamilton Virginia			
24. FUNERAL DIRECTOR Teele Funeral Home		ADDRESS Brunswick Md.		25a. REC'D BY REGISTRAR DATE 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

68130



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08186

CERTIFICATE OF DEATH

08172

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Weeks		b. COUNTY Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wynelle Nursing Home			d. STREET ADDRESS 910 Chestnut Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GRACE		First L.	Middle SCHAFFER	4. DATE OF DEATH Month June	Day 7	Year 19 67	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 7, 1889	9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frederick County, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Zimmerman			14. MOTHER'S MAIDEN NAME Amanda M. Staley			Address Frederick, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215 36 6826 D		17. INFORMANT Mrs. John A. Summers, Route #5,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary artery disease stating the underlying cause (c) Generalized arteriosclerosis	
INTERVAL BETWEEN ONSET AND DEATH 10 days - 6 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to 6/7 , 19 67 that (I) (we) last saw the deceased alive on 6/3 19 67 , and that death occurred at 6A M, from causes and on the date stated above.							
22a. SIGNATURE James B. Thomas		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 8, 1967	
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22d. ADDRESS 228 N. Market St. Frederick, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 10, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Donald M. Staley ADOPTED M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

63129

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08187

CERTIFICATE OF DEATH

08173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Douglas B.F. S.D.</i>		c. LENGTH OF STAY IN lb <i>4 yrs.</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Douglas Rural</i>		e. STREET ADDRESS <i>101</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARVEY THEODORE SCHWARTZBECK		First	Middle
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. ODECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		9. AGE (In years last birthday) <i>51 yrs.</i>	10. DATE OF BIRTH <i>Apr. 16 1916</i>
10. KIND OF BUSINESS OR INDUSTRY <i>House Building</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William Schwartzbeck</i>		14. MOTHER'S MAIDEN NAME <i>Mary Custer #</i>	
15. WAS ODECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>578-05-9610</i>	17. INFORMANT <i>Mrs. Carolyn Schwartzbeck</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>4201</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>Coronary Occlusion</i>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <i>hypertensive cardiovascular disease</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>None</i>		(County) <i>None</i>	
(State) <i>None</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>1964</i> , 1966, to <i>May</i> , 1967 that (I) (we) last saw the deceased alive on <i>5/24</i> 1967, and that death occurred at <i>M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>J.R. Poirier M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>6/7/67</i>
22c. PHYSICIAN'S NAME (Type) <i>J.R. Poirier M.D.</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Douglas</i>		23b. DATE THEREOF <i>6/9/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Paul</i>
24. FUNERAL DIRECTOR <i>Constance C. Hilton Barnesville, Md.</i>		ADDRESS <i>Barnesville, Md.</i>	25a. LOCATION (City or Town) <i>Baltimore Rock Fred. Md.</i>
			(County) <i>Baltimore Rock Fred. Md.</i>
			(State) <i>Baltimore Rock Fred. Md.</i>
25b. REC'D BY REGISTRAR <i>Charles Judge</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>JUN 12 1967</i>			

7830

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

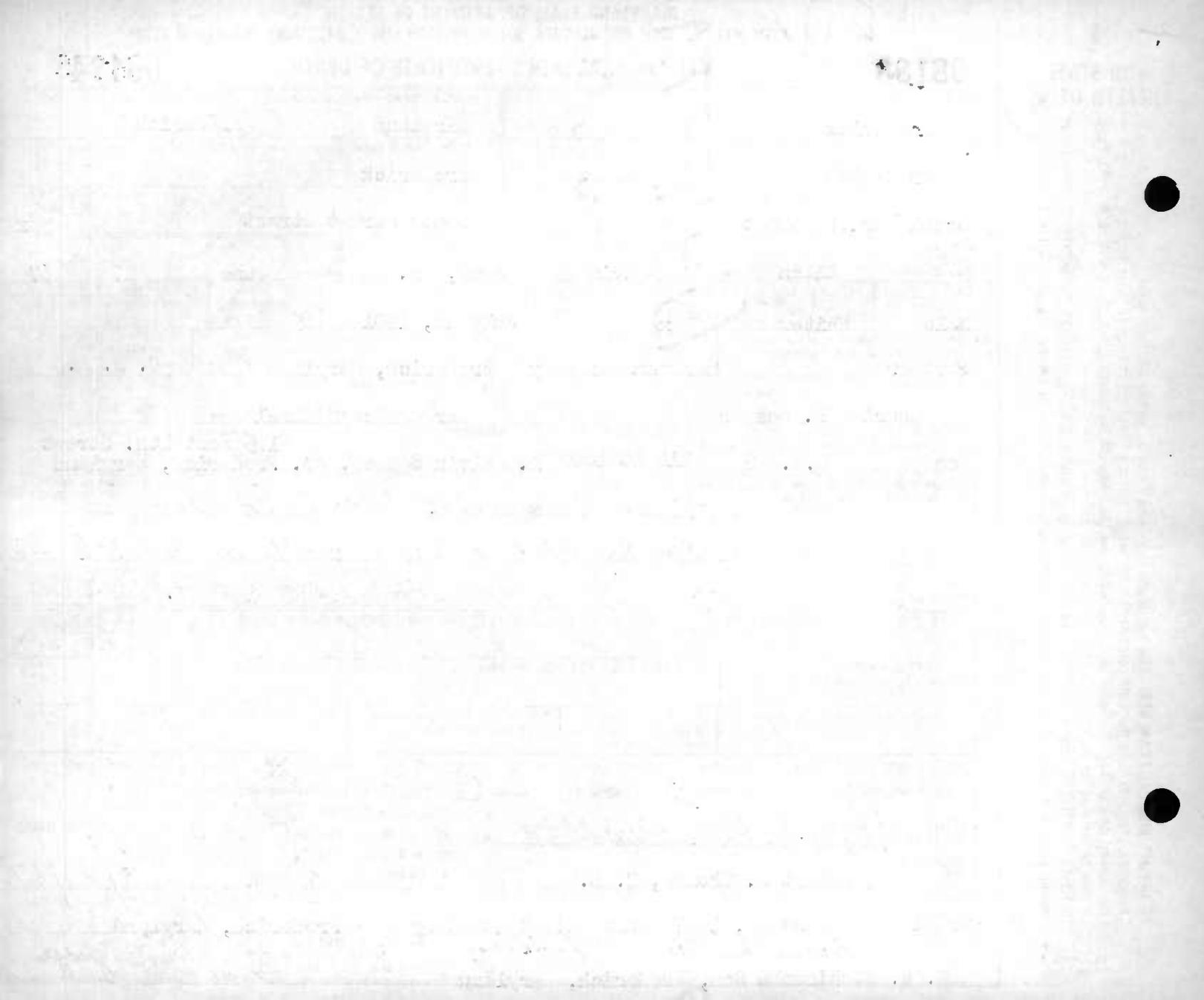
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08188

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08174

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		10'1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 South Market Street				d. STREET ADDRESS 5 South Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Allen		First Melvin	Middle Seeger, Sr.	Lost	4. DATE OF DEATH June 27	Month 1967	Day 67
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1901	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0 Hours 0 Min. Address 105 East 4th. Street
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner		10b. KIND OF BUSINESS OR INDUSTRY Hardware Company		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles F. Seeger				14. MOTHER'S MAIDEN NAME Marguerite Michael			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. # 2		16. SOCIAL SECURITY NO. 214 10 1600		17. INFORMANT A. Melvin Seeger, Jr.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO (b) Coronary Artery Occlusion - Myocardial Infarction DUE TO (c) Arteriosclerotic Cardiovascular Disease	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While Not While of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Robert J. Thomas		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Robert J. Thomas, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 29, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Donald M. Fadley		ADDRESS M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR JUN 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08183

CERTIFICATE OF DEATH

08175

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Frederick		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg 104		d. STREET ADDRESS Route # 2							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Carroll		First Joseph	Middle Shelton	Lost June	4. DATE OF DEATH Feb. 27, 1967	Month 21	Day 19	Year 67					
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1903	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0				
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming				11. BIRTHPLACE (County & State, or foreign country) Fred. Co., Maryland					
13. FATHER'S NAME James William Shelton				14. MOTHER'S MAIDEN NAME Estella Mc Kinney				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 215-14-2850				17. INFORMANT Mr. Raymond Shelton, Emmitsburg, Md. R # 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Massive Coronary Occlusion				10 min									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary Insufficiency				2 yrs									
DUE TO (b) Arteriosclerotic Cardiovascular Disease				2 yrs									
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Embolism, Low Grade Heart Failure													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury from fall				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Ladiesburg, Frederick, Md.		(County) Frederick		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 10/18 , 19 59 , to 6/21 , 19 67 , that (I) (I) last saw the deceased alive on 6/20 , 19 67 , and that death occurred at Ladiesburg M, fram causes and on the date stated above.													
22a. SIGNATURE E. Ambler Thompson				M.D.				ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) E. Ambler Thompson, M.D.				22d. ADDRESS Taneytown, Maryland				22b. DATE SIGNED 6/22/67					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Haugh's Cemetery		23d. LOCATION (City or Town) Ladiesburg, Frederick, Md.		(County) Frederick		(State) Md.			
24. FUNERAL DIRECTOR John M. Skiles				ADDRESS Taneytown, Md.				25a. RECD BY REGISTRAR JUN 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
C.O. Fuss & Son													

2180

2
2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08176

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 204 Maple Avenue		e. STREET ADDRESS 204 Maple Avenue	
3. NAME OF DECEASED (Type or print) RENO OSBORNE		First RENO	Middle OSBORNE
Last SIX		4. DATE OF DEATH June 21 1967	Month Day Year
S. SEX Male		5. COLOR OR RACE White	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. B. DATE OF BIRTH August 13, 1905		8. AGE (In years from birth day) 61 yrs.	9. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Fred. City Policeman	11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Osborne Six	
14. MOTHER'S MAIDEN NAME Mamie Boone		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Agnes Six, (Same as item # 2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)		DUE TO <i>Congestive heart failure</i> DUE TO <i>Arterio - sclerotic CVD.</i> DUE TO <i>Coronary thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April 1, 1967</i> to <i>June 21, 1967</i> , that (I) (we) last saw the deceased alive on <i>June 20, 1967</i> , and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>June 22, 1967</i>	
22a. SIGNATURE <i>Bernard O. Thomas, Jr.</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr. M. D.		22d. ADDRESS 228 N. Market Street, Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mount Olivet Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Donald M. Fadley M. R. Etchison & Son, Frederick, Maryland		23d. LOCATION (City, town or county) Frederick, Maryland	(State)
		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
		DATE JUN 26 1967	

02180

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

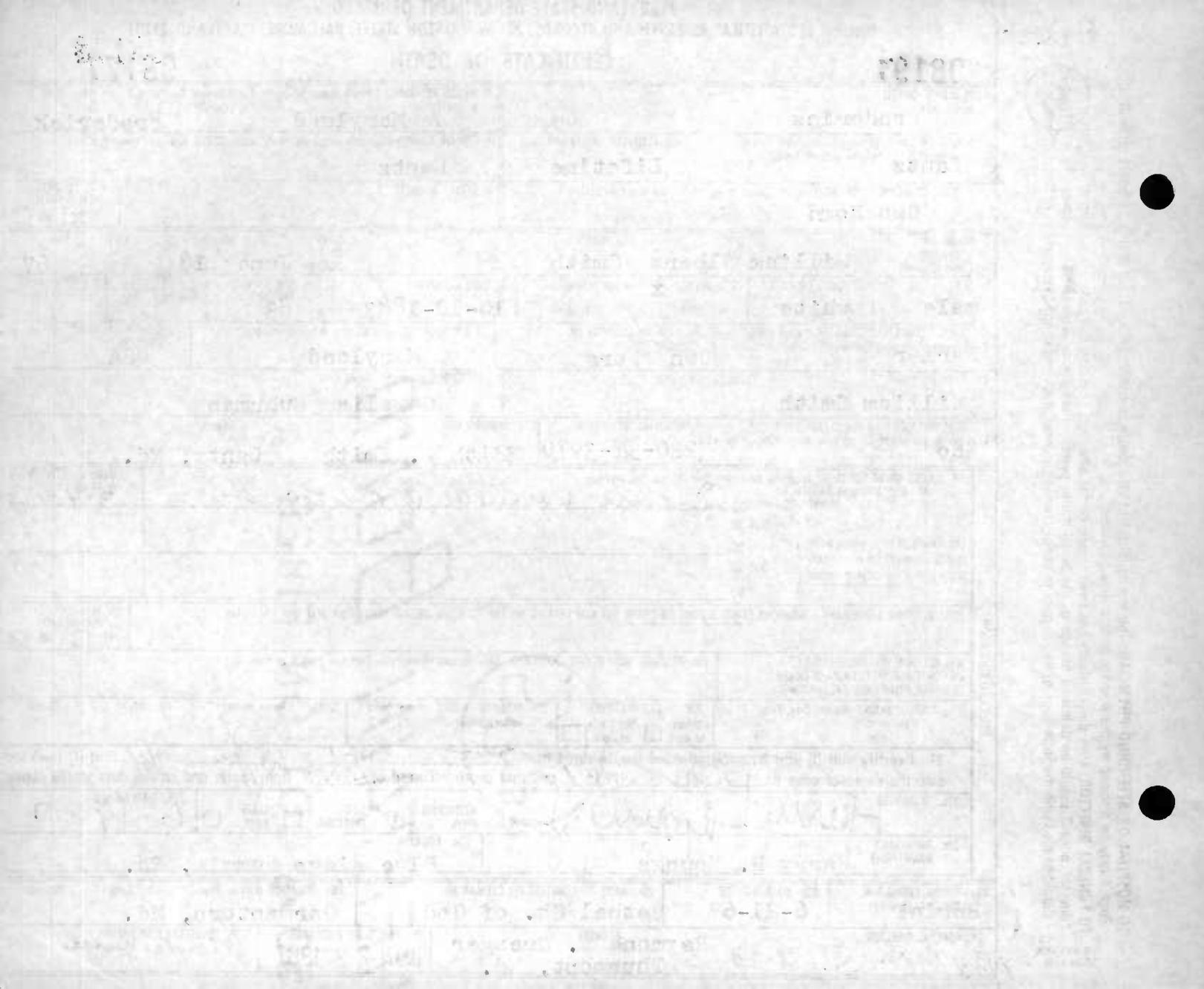
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08191

CERTIFICATE OF DEATH

08177

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz	c. LENGTH OF STAY IN lb Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William Albert Smith		First William	Middle Albert
4. DATE OF DEATH Month June	Month 18	Doy 19	Year 67
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 10-10-1883	9. AGE (In years last birthday) 83 yrs.	10. KIND OF BUSINESS OR INDUSTRY Own Farm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Camelia Buhrman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-54-3970	
17. INFORMANT Edith L. Smith		Address Lantz, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
33/X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Blue Ridge Summit, Pa.
20f. (City or town) Germantown, Md.		(County) Maryland	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 7-5 , 19 61 , to 18 June , 19 67 , that (I) (we) lost saw the deceased alive on 17 June , 19 67 , and that death occurred at 4304 M. from causes and on the date stated above.		22b. DATE SIGNED 6-19-67.	
22a. SIGNATURE Harry H. Youngs		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Harry H. Youngs		22d. ADDRESS Blue Ridge Summit, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-67	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Ch. of God
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR JUN 22 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08192

CERTIFICATE OF DEATH

08178

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 277 W. 5th. St.	
e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elsie	Middle Marie	Last Solt
4. DATE OF DEATH	Month June	Day 24-	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8- 1909
9. AGE (in years last birthday) 57 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper	10b. KIND OF BUSINESS OR INDUSTRY Hosp. Diet Kitchen	11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME James Elmer Solt		
14. MOTHER'S MAIDEN NAME Bertie L. Haller	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 218-38-1251		
17. INFORMANT Mrs. Myrtis S. Albaugh-277 W. 5th. St.-			Address Frederick, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>157X</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Congestive Heart Failure</i> <i>Carcinoma Body + Tail</i> <i>of Pancreas</i>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <i>James B Thomas</i>		22b. DATE SIGNED 6-25-67	
22c. PHYSICIAN'S NAME (Type) Dr. James B. Thomas	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Prof. Bldg.- Frederick, Md. 21701
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 27-1967	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR M.R. Etchison & Son	ADDRESS Elwood T. Whitmore	25a. REC'D BY REGISTRAR DATE JUN 28 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08193

CERTIFICATE OF DEATH

08179

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham		c. LENGTH OF STAY IN 1b 25 yrs.		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham		d. STREET ADDRESS Own Home		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leslie R. Sovocool		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Leslie R. Sovocool		First Leslie	Middle R.	
4. DATE OF DEATH June 18 1967	Month June	Doy 18	Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 11-7-1902	
9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Teacher	10b. KIND OF BUSINESS OR INDUSTRY Public school	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Sovocool	14. MOTHER'S MAIDEN NAME Carrie M. Hesser	Address Clara E. Sovocool Graceham, Md.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-09-8070	17. INFORMANT Clara E. Sovocool	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) DUE TO Coronary Artherosclerosis DUE TO 4201 C PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) -	INTERVAL BETWEEN ONSET AND DEATH immediate ±2 yrs -
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	20f. (City or town) (County) (State) -
21. I certify that (I) (this hospital) attended the deceased from 1-67 , 19 67 , to 6-18 , 19 67 , that (I) (we) last saw the deceased alive on 6-18 , 19 67 , and that death occurred at 4201 M, from causes and on the date stated above.				
22a. SIGNATURE Thomas A. Love		M.D. <input type="checkbox"/> ATTENDING PHYS. Thomas A. Love	MED. DIRECTOR <input type="checkbox"/> Thomas A. Love	STAFF PHYS. <input type="checkbox"/> Thomas A. Love
22c. PHYSICIAN'S NAME (Type) Thomas A. Love		22d. ADDRESS Thurmont, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-22-67	23c. NAME OF CEMETERY OR CREMATORIAL Graceham Cemetery	23d. LOCATION (City or Town) (County) (State) Graceham, Md. Fred Co.
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR JUN 22 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08194

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08180

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Frederick	c. LENGTH OF STAY IN 1b ?	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Airy	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reich's Ford		d. STREET ADDRESS R.D. 4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BRENDA	First J.	Middle STITLEY	4. DATE OF DEATH Month June Day 25, Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1954
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Frederick, Md.	
13. FATHER'S NAME Ernest Stitley		14. MOTHER'S MAIDEN NAME Daisey Mercer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Ernest Fritz Same As #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9298 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { (b) (c)		DUE TO Congestive Heart Failure DUE TO Suffocation DUE TO Drowning	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into 8' hole in river - could not swim	
20c. TIME OF INJURY Month, Day, Year 12:30 p.m. 6-25-67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	
20f. (City or town) Frederick-Frederick Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) ROBERT J. THOMAS, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/1967	
23c. NAME OF CEMETERY Locust Grove		23d. LOCATION (City or Town) (County) (State) Frederick Co., Md.	
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR JUN 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

36130

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G389 6/14/67 pc

08195

CERTIFICATE OF DEATH

08181

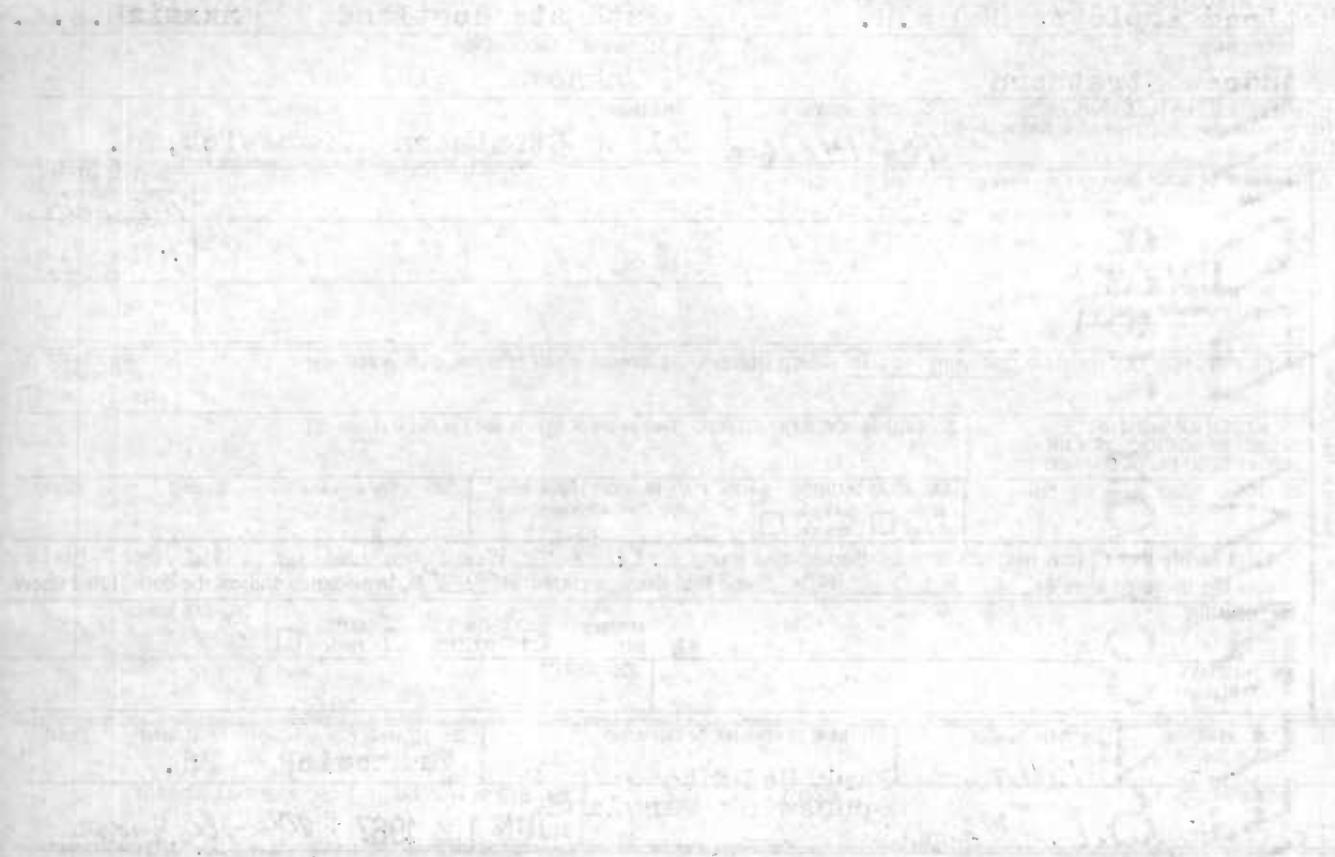
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. ~~Please sign and file~~
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. ~~Please sign and file~~
should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue Infirmary		d. STREET ADDRESS Resident (Montevue)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANDREW FLEMING STRATHERN		First ANDREW	Middle FLEMING
3. NAME OF DECEASED (Type or print) ANDREW FLEMING STRATHERN		Lost STRATHERN	4. DATE OF DEATH 6 Month 6 Day 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/22/01
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired employee B&O R.R.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Bathgate Scotland		12. CITIZEN OF WHAT COUNTRY? Scotia U.S.A.	
13. FATHER'S NAME Andrew Strathern		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-14-1600	
17. INFIRMARY		Address Nelson Strathern Brunswick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio - sclerotic C.V.D. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) None (County) None (State) None		21. I certify that (I) (this hospital) attended the deceased from not , 19 63 to June 6 , 19 67 , that (I) (we) last saw the deceased alive on June 5 19 67 , and that death occurred at 12:30 P.M. from causes and on the date stated above.	
22a. SIGNATURE Bernard O'Toole Jr		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6/8/67
22c. PHYSICIAN'S NAME (Type) Bernard O'Toole Jr		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/9/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Park Heights
23d. LOCATION (City or Town) Brunswick (County) Md. (State) None		23e. REC'D BY REGISTRAR DAJUN 12 1967	
23f. FUNERAL DIRECTOR Feele Funeral Home		23g. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08196

CERTIFICATE OF DEATH

08182

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Havoco	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. STREET ADDRESS 85-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Marion	Middle 	Last Stroupe
4. DATE OF DEATH June 26 1967	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/7/01
8. IF UNDER 1 YEAR Months 6	9. AGE (In years last birthday) yrs. 65	10. IF UNDER 24 HRS. Days 0	11. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas Dickens		14. MOTHER'S MAIDEN NAME Frances Groseclose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 233-07-8440	
17. INFORMANT Paul Stroupe - Brunswick Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive heart failure DUE TO 253X INTERVAL BETWEEN ONSET AND DEATH 4-5 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia, reverse DUE TO 2-3 yrs (c) Hypothyroidism DUE TO ??			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Roderfield
20f. (City or town) Roderfield		(County) West Va.	
		(State)	
21. I certify that (I) (this hospital) attended the deceased from 26 June 1967 , to 26 June 1967 , that (I) (we) last saw the deceased alive on 26 June 1967 , and that death occurred at 7:30 P.M. , from causes and on the date stated above.		22b. DATE SIGNED 26-June-67	
22a. SIGNATURE Henry V Chase		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS 804 Toll House Ave Frederick, Md
22c. PHYSICIAN'S NAME (Type) Henry V. Chase MD		22d. ADDRESS Laeger Memorial Cem. Roderfield West Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-30-67		23b. DATE THEREOF 6-30-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Laeger Memorial Cem. Roderfield West Va.
24. FUNERAL DIRECTOR Feele Funeral Home		25a. RECEIVED BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
		DATE JUN 28 1967	

36130

1960

student

for more information

George

George

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08197

CERTIFICATE OF DEATH

08183

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

Years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

600 Military Road

First

Middle

Last

Month

Dey

Year

3. NAME OF
DECEASED
(Type or print)

Margaret

C.

Warner

4. SEX

6. COLOR OR RACE

Female

White

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

May 26, 1921

9. AGE (In years
last birthday)

46 yrs.

10. UNDER 1 YEAR

Months Days Hours Min.

e. IS RESIDENCE
ON A FARM?
YES NO

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Supv. Telephone Office

10b. KIND OF BUSINESS OR INDUSTRY

Sears Roebuck Co.

11. BIRTHPLACE (County & State, or foreign country)

Woodsboro, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Clyde Bentz

14. MOTHER'S MAIDEN NAME

Lottie Kaufman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

217 12 2069 m Wilbur D. Warner, Sr. (Same as item #2)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

190X

DUE TO

Metastatic carcinoma - lungs,

INTERVAL BETWEEN
ONSET AND DEATH

1 year

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Spine

2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1967 to June 20, 1967, that (I) (we) last
saw the deceased alive on June 19, 1967, and that death occurred at M. from the causes and on the date stated above.

22a. SIGNATURE

Bernard O. Thomas Jr.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
June 21, 1967

22c. PHYSICIAN'S
NAME (Type)

Bernard O. Thomas, Jr. M. D.

22d. ADDRESS

228 N. Market St. Frederick, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial June 22, 1967 Mount Olivet Cemetery

23d. LOCATION (City, town or county)

(State)

Frederick, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE Donald M. Federley

M. R. Etchison & Son, Frederick, Maryland

25a. REC'D BY REGISTRAR

JUN 26 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

0818

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13
08198

CERTIFICATE OF DEATH

08184

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		d. STREET ADDRESS 101 Prospect Road			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DANIEL		First	Middle	Lost	4. DATE OF DEATH WILSON, SR.	Month June	Doy 10	Year 19 67	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1897	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jesse R. Wilson		14. MOTHER'S MAIDEN NAME Mary K. Duvall							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-6348A		17. INFORMANT Mr. Daniel D. Wilson, Jr.		Address Mt. Airy, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presenilus						INTERVAL BETWEEN ONSET AND DEATH			
5020 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO Alcoholism	(b) Congestive Heart Failure	DUE TO Chronic bronchitis and emphysema					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) alcoholism									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) injury occurred while at work		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20f. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>							
21. I certify that (1) this hospital attended the deceased from 6/9/62 , 19, to 6/10/62 , 19, that (1) (we) last saw the deceased alive on 6/10/62 , 19, and that death occurred at 1200P M, from causes and on the date stated above.									
22o. SIGNATURE A. Austin Pearre, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/10/62	
22c. PHYSICIAN'S NAME (Type) Dr. A. Austin Pearre, Jr.		22d. ADDRESS 4 E. Church St., Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/1967		23c. NAME OF CEMETERY OR CREMATORIAL Prospect Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick Co., Md.			
24. FUNERAL DIRECTOR Charles Waltz		ADDRESS Waltz Box 241 Sykesville, Md.		25a. REC'D. BY REGISTRAR DATE JUN 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

32136

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

08193

CERTIFICATE OF DEATH

08185

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 507 Grant Place		d. STREET ADDRESS 507 Grant Place	
3. NAME OF DECEASED (Type or print) John W. Wolf		First	Middle
Last		Last	4. DATE OF DEATH June 22- 19 67
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29-1885
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Assoc. Cigar Factory	11. BIRTHPLACE (County & State, or foreign country) York Co. Pa.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Michael Wolf	
14. MOTHER'S MAIDEN NAME Not available		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) No	
16. SOCIAL SECURITY NO. 186-01-0427		17. INFORMANT Mrs. Lydia M. Ness Wolf-507 Grant Place-	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address Frederick, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5-10 Min.	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO		Acute coronary occlusion	
		Hypertensive + arteriosclerotic Heart Disease	
10-20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebro vascular Thrombosis c. rt. hemiplegia since 1960			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 23-67	
22c. PHYSICIAN'S NAME (Type) Dr. R.L. Michels		22d. ADDRESS Frederick Medical Center-Frederick, Md.	
23e. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF June 26-1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Red Lion Cemetery Whitmore		23d. LOCATION (City, town or county) Red Lion- Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Elwood T. M.R. Etchison & Son		25a. REC'D BY REGISTRAR DATE JUN 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

